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Gender Affirming Services (Trans Services) Corporate Medical Policy

File Name: Trans Services
File Code: 7.01.VT202
Origination: 05/30/2011
Last Review: 12/2021
Next Review: 12/2022
Effective Date: 03/01/2022

Description/Summary

This policy focuses on non-surgical and surgical treatments as components of gender affirming services for trans and gender diverse people.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I- CPT® code table & instructions
Attachment II- ICD-10-CM code table

Non-Surgical Treatment

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

When a service may be considered medically necessary

Feminizing/masculinizing hormone therapy is considered **medically necessary** when all the following criteria are met:

- Persistent, well-documented gender non-conformity; **AND**

- Capacity to make a fully informed decision and to consent for treatment; **AND**

  Note: Initiation of feminizing/masculinizing hormone therapy may be provided after a psychosocial assessment has been conducted and informed consent has been obtained by a health professional. Parent or Guardian permission is necessary for patients under the age of 18 years old.

- Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the member's situation and functioning are stable enough to start treatment; **AND**

- For the hormone therapy requested:
  - The member has an on-label indication and meets the plan's prior approval criteria for the hormone drug; OR
  - The member has an off-label indication and meets the plan's prior approval criteria for the hormone drug; OR
  - The member has an off-label indication and meets the plan's Off-Label Drug Corporate Medical Policy criteria;

Feminizing or masculinizing speech therapy and/or voice training services for trans and gender diverse people with or without additional health diagnoses are covered services.

Trans Specific Cancer Screenings

When a service may be considered medically necessary

Specific screenings may be considered **medically necessary** for trans persons appropriate to their anatomy. Examples include:

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

SURGICAL TREATMENT

Surgical treatment to change primary sexual characteristics for gender affirmation may be eligible when medical necessity and documentation requirements outlined within this policy are met.

When a service may be considered medically necessary

Surgical treatment for gender affirmation may be considered **medically necessary** when **ALL** of the following criteria are met:

- The individual is at least 18 years of age; **OR**
- For individuals under 18 years of age, who meet the following criteria (Exception to Age 18 Criteria):
    - Chest surgery for trans men or gender diverse individuals under 18 years of age may be considered **medically necessary** after one year of living in the desired gender role and one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust to their gender, before undergoing irreversible surgery; **AND**
    - For individuals under 18 years of age, the following must be submitted as evidence of puberty completion:
        - Documented tanner stage IV or V for members aged 15-18**; AND**
        - Stable height measurements for 6 months; **OR**
        - Puberty completion as shown on wrist radiograph; **AND**
- The individual demonstrates a marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 months' duration, as manifested by at least **TWO** of the following:
    - A strong desire to be rid of one's birth gender; **OR**
    - A strong desire to be an alternative gender different from one's birth gender; **OR**
    - A strong desire to be treated as an alternative gender different from one's birth gender; **OR**
    - A strong conviction that one has the typical feelings and reactions of an alternative gender different from one's birth gender
- The condition is associated with distress or impairment in social, occupational, or other important areas of functioning
- Unless medically contraindicated, there is documentation that the individual has participated in 12 consecutive months of cross-sex hormone therapy of the desired gender continuously and responsibly (e.g., screenings and follow-ups with the professional provider)
  NOTE: Hormone therapy is not a prerequisite for mastectomy
- Documentation that the individual has knowledge of all practical aspects (e.g., required lengths of hospitalizations, likely complications, and post-surgical rehabilitation) of the gender affirmation surgery
- One current (within the past 12 months) referral letter from a qualified mental health professional who has assessed the patient's readiness for chest (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty) or genital surgery. Referral letters for surgery must include the following clinical information:
    - Results of the patient's psychosocial assessment, including any diagnoses
    - The patient's general identifying characteristics
    - The duration of the mental health professional's relationship with the patient including the type of evaluation and therapy or counseling to date
    - Attestation that the patient has completed 12 months of continuous, full-time, real-life experience (i.e., the act of fully adopting a new or evolving gender role or gender presentation in everyday life) in the desired gender,

including for example one or more of the following:
    - Maintain part-time or full-time employment; **OR**
    - Function as a student in an academic setting; **OR**
    - Function in a community-based volunteer activity.
- A brief description of the clinical rationale supporting the patient's request for surgery.

When all of the above criteria are met for gender affirmation surgery, the following genital surgeries may be considered **medically necessary** for trans and gender diverse people:

- Penectomy
- Vaginoplasty
- Labiaplasty
- Mammaplasty
- Prostatectomy
- Urethroplasty

NOTE: Genital Electrolysis may be considered **medically necessary** when required by a surgeon as a mandatory prerequisite immediately prior to any of the above procedures

- Vaginectomy
- Vulvectomy
- Metoidioplasty
- Phalloplasty
- Urethroplasty
- Scrotoplasty
- Testicular prostheses implantation

NOTE: Excision of excessive skin and subcutaneous tissue, mons resection may be considered **medical necessary** only when performed in conjunction/preparation for the procedures listed above

When all of the above criteria are met for gender affirmation surgery, the following chest surgery may be considered **medically necessary**:

- Breast reconstruction (e.g. mastectomy)

NOTE: Breast reduction surgery is not part of gender affirmation surgery - refer to BCBSVT Breast Surgery Corporate Medical Policy

When all of the above criteria are met for gender affirmation surgery, the following gender affirming facial/neck surgeries may be considered **medically necessary**:

- Forehead contouring
- Scalp advancement (only as needed in conjunction with forehead contouring). ()
- Rhinoplasty

- Mandible reconstruction
- Trachea shave
- Cheek augmentation
- Face lift or liposuction (only as needed in conjunction with one of the above procedures).
- Neck lift (only if the excess skin impairs the outcome of the covered facial feminization or masculinization procedures).

All surgical treatments for gender affirmation require prior approval except:

- Orchiectomy
- Salpingo-oophorectomy
- Hysterectomy

Surgical Revisions and Reconstruction

Reconstructive chest and genital surgery following gender affirmation surgery may be considered MEDICALLY NECESSARY when it is performed to:

• Correct complications resulting from the initial surgery OR
• Correct functional impairment resulting from initial surgery.

A referral letter from a mental health professional is not needed.

When service is considered not medically necessary and therefore not covered

- Services or procedures when medical necessity and documentation requirements outlined within this policy are not met.
- When prior approval is not obtained.
- Reversal of a gender transition including reversal of gender affirmation surgery
- Treatment with hormones or medications to reverse a gender transition
- Reconstructive surgery following gender affirmation surgery to reverse natural signs of aging or if the member is not satisfied with the surgical result.

The following services are considered a benefit exclusion and therefore not covered

Cosmetic Services

Services for the purpose of changing secondary sexual characteristics are considered cosmetic and contract exclusions for all products of the Plan and therefore not covered. Including but not limited to:

- Blepharoplasty: removal of redundant skin of upper and/or lower eyelids and protruding periorbital fat
- Hair removal or hair transplantation (except as noted above)
- Collagen injections
- Lip reduction/enhancement: decreasing/enlarging lip size

- Cricothyroid approximation: voice modification that raises the vocal pitch by simulating contractions of the cricothyroid muscle with sutures
- Laryngoplasty: reshaping of laryngeal framework (voice modification surgery)
- Mastopexy: breast lift

For a list of additional services that are considered cosmetic and therefore, non-covered, refer to BCSBVT Medical Policy for Cosmetic and Reconstructive procedures.

Policy Guidelines

DOCUMENTATION INFORMATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

See coding tables below for procedures (Attachment I), and diagnosis (Attachment II) which are eligible per this medical policy. Procedures listed below may be eligible when medical necessity and documentation requirements outlined within this policy are met.

BILLING GUIDELINES

When reporting procedure code 55970 (Intersex surgery; male to female), the following staged procedures to remove portions of the male genitalia and form female external genitals are included:

- The penis is dissected, and portions are removed with care to preserve vital nerves and vessels in order to fashion a clitoris-like structure.
- The urethral opening is moved to a position similar to that of a female.
- A vagina is made by dissecting and opening the perineum. This opening is lined using pedicle or split- thickness grafts.
- Labia are created out of skin from the scrotum and adjacent tissue.
- A stent or obturator is usually left in place in the newly created vagina for three weeks or longer.

When reporting procedure code 55980 (Intersex surgery; female to male), the following staged procedures to form a penis and scrotum using pedicle flap grafts and free skin grafts are included:

- Portions of the clitoris are used, as well as the adjacent skin.
- Prostheses are often placed in the penis to create a sexually functional organ.
- Prosthetic testicles are implanted in the scrotum.
- The vagina is closed or removed.

Reference Resources

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14. The World Professional Association for Transgender Health, Inc. (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People Version 8. Draft for public comment. Surgery. Accessed 12/13/2021.
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Related Policies

Breast Surgery and Breast Prosthesis

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between

medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

05/30/2011	New Policy- UVM Coverage only. Excluded from all other contracts.
10/2012	Minor format changes. No coding changes. Medical/Clinical Coder reviewed.
05/2013	Reviewed for health exchange/ new DFR regulation. "Unfair discrimination", Insurance Bulletin No. 174. Added coding tables for CPT® and ICD-9 and ICD-10. Removed language that was specific to UVM group coverage and removed language pertaining to GD/Transgender exclusions since the exclusions no longer apply. RLJ.

06/2016	Changes made based on WPATH standards of care. Hormone Therapy clarified. Diagnosis codes added.
6/2017	Changes made based on WPATH standards of care in reference to under age 18 criteria exceptions. Reference updated, removed description section, minor formatting changes. Updated descriptors of CPT and ICD 10 codes. Removed duplicated code table. Added ICD 10 F64.0 under ICD 10 table.
03/2019	Removal of letter and prior approval requirement for hysterectomy, salpingo-oophorectomy and orchiectomy. Added an additional female to male genital surgery procedure Code 15240, 17380 requires prior authorization. Codes 52520, 54690, 58150, 58180, 58260, 58262, 58275, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, ,58572, 58573, 58720 removed from requiring prior approval to not requiring prior approval. Code 15830 removed from benefit exception to requiring prior approval. Added language around electrolysis. Removed code ranges in procedure table. Code 17380 requires prior authorization.
07/2019	Reviewed added codes 15200 requires prior approval. Updated references.
10/2020	Medical necessity criteria added for Hormone Therapy. Policy formatted and language clarified. References updated. Removed code 19304 effective 01/01/2020.
12/2021	Policy reviewed. Name changed from Transgender Services to Gender Affirming Services (Trans Services). Medical necessity changed to include Facial Surgery consistent with WPATH SOC 8 draft updated language to include gender diverse individuals, removed two letter referral requirement and updated references. New table created for facial surgery with the following summary: added Facial surgery codes: 15824, 15825, 15826, 15828, 15876, 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21208, 21209, 21270, 21299, 21499, 30400, 30410, 30420, 31599. Updated Benefit Exclusion table.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Attachment I
CPT® Code Table & Instructions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
Trans woman procedures (male to female)			
CPT®	15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	Prior approval required
CPT®	15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	Prior approval required
CPT®	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Prior approval required
CPT®	17380	Electrolysis, epilation, each 30 minutes	Prior approval required
CPT®	19325	Mammaplasty, augmentation; with prosthetic implant	Prior approval required
CPT®	19350	Nipple/areola reconstruction	Prior approval required
CPT®	53430	Urethroplasty, reconstruction of female urethra	Prior approval required
CPT®	54125	Amputation of penis; complete	Prior approval required
CPT®	54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Prior approval is not required

CPT®	54690	Laparoscopy, surgical; orchiectomy	Prior approval is not required
CPT®	55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed.	Prior approval required
CPT®	55970	Intersexsurgery; male to female	See "Billing Guidelines" section of this medical policy for instructions on this code. Prior approval required
CPT®	56800	Plastic repair of introitus	Prior approval required
CPT®	56805	Clitoroplasty for intersex state	Prior approval required
CPT®	57291	Construction of artificial vagina; without graft	Prior approval required
CPT®	57292	Construction of artificial vagina; with graft	Prior approval required
CPT®	57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	Prior approval required
CPT®	57296	Revision (including removal) of prosthetic vaginal graft, open abdominal approach	Prior approval required
CPT®	57335	Vaginoplasty for intersex state	Prior approval required
CPT®	57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Prior approval required
Trans man procedures (female to male) or Gender Diverse			
CPT®	19303	Mastectomy, simple, complete	Prior approval required
CPT®	19350	Nipple/areola reconstruction	Prior approval required
CPT®	53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	Prior approval required
CPT®	53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	Prior approval required

CPT®	54660	Insertion of testicular prosthesis (separate procedure)	Prior approval required
CPT®	55175	Scrotoplasty; simple	Prior approval required
CPT®	55180	Scrotoplasty; complicated	Prior approval required
CPT®	55980	Intersex surgery; female to male	See "Billing Guidelines" section of this medical policy for instructions on this code. Prior approval required
CPT®	56625	Vulvectomy simple; complete	Prior approval required
CPT®	57106	Vaginectomy, partial removal of vaginal wall	Prior approval required
CPT®	57110	Vaginectomy, complete removal of vaginal wall	Prior approval required
CPT®	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tubes(s), with or without removal of ovary(s)	Prior approval is not required
CPT®	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Prior approval is not required
CPT®	58260	Vaginal hysterectomy, for uterus 250g or less	Prior approval is not required
CPT®	58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tubes(s) and/or ovary(s)	Prior approval is not required
CPT®	58275	Vaginal hysterectomy, with total or partial vaginectomy	Prior approval is not required
CPT®	58290	Vaginal hysterectomy, for uterus greater than 250g	Prior approval is not required
CPT®	58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tubes(s) and/or ovary(s)	Prior approval is not required

CPT®	58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less	Prior approval is not required
CPT®	58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval is not required
CPT®	58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g	Prior approval is not required
CPT®	58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval is not required
CPT®	58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less	Prior approval is not required
CPT®	58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval is not required
CPT®	58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g	Prior approval is not required
CPT®	58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval is not required
CPT®	58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less	Prior approval is not required
CPT®	58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)	Prior approval is not required
CPT®	58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g	Prior approval is not required

CPT®	58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)	Prior approval is not required
CPT®	58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (Separate procedure)	Prior approval is not required
Facial Surgery			
		Brow Reconstruction	
CPT®	21137	Reduction forehead; contouring only	Prior approval required
CPT®	21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	Prior approval required
CPT®	21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Prior approval required
CPT®	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior approval required
CPT®	21209	Osteoplasty, facial bones; reduction	Prior approval required
CPT®	21299	Unlisted craniofacial and maxillofacial procedure	Prior approval required
CPT®	21499	Unlisted musculoskeletal procedure, head	Prior approval required
		Rhinoplasty	
CPT®	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior approval required
CPT®	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Prior approval required
CPT®	30420	Rhinoplasty, primary; including major septal repair	Prior approval required
		Cheek Augmentation	

CPT®	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior approval required
CPT®	21270	Malar augmentation, prosthetic material	Prior approval required
CPT®	21209	Osteoplasty, facial bones; reduction	Prior approval required
		Jaw Reconstruction	
CPT®	21125	Augmentation, mandibular body or angle; prosthetic material	Prior approval required
CPT®	21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	Prior approval required
CPT®	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior approval required
CPT®	21209	Osteoplasty, facial bones; reduction	Prior approval required
CPT®	21299	Unlisted craniofacial and maxillofacial procedure	Prior approval required
CPT®	21499	Unlisted musculoskeletal procedure, head	Prior approval required
		Chin Reconstruction	
CPT®	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Prior approval required
CPT®	21121	Genioplasty; sliding osteotomy, single piece	Prior approval required
CPT®	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	Prior approval required
CPT®	21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Prior approval required
CPT®	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior approval required

CPT®	21209	Osteoplasty, facial bones; reduction	Prior approval required
CPT®	21299	Unlisted craniofacial and maxillofacial procedure	Prior approval required
CPT®	21499	Unlisted musculoskeletal procedure, head	Prior approval required
		Facelift	
CPT®	15824	Rhytidectomy; forehead	Prior approval required
CPT®	15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Prior approval required
CPT®	15826	Rhytidectomy; glabellar frown lines	Prior approval required
CPT®	15828	Rhytidectomy; cheek, chin, and neck	Prior approval required
		Liposuction	
CPT®	15876	Suction assisted lipectomy; head and neck	Prior approval required
		Trachea Shave	
CPT®	31599	Unlisted procedure, larynx	Prior approval required
The following codes are considered cosmetic and will be denied as contract exclusions, therefore not covered. (This list may not be all-inclusive.)			
CPT®	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Contract Exclusion
CPT®	11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Contract Exclusion
CPT®	11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0	Contract Exclusion
CPT®	11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Contract Exclusion
CPT®	15775	Punch graft for hair transplant	Contract Exclusion
CPT®	15776	Punch graft for hair transplant; more than 15 punch grafts	Contract Exclusion

CPT®	15820	Blepharoplasty	Refer to cosmetic medical policy
CPT®	15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Refer to cosmetic medical policy
CPT®	15822	Blepharoplasty, upper eyelid;	Refer to cosmetic medical policy
CPT®	15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Refer to cosmetic medical policy
CPT®	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Contract Exclusion
CPT®	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Contract Exclusion
CPT®	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Contract Exclusion
CPT®	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Contract Exclusion
CPT®	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Contract Exclusion
CPT®	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Contract Exclusion
CPT®	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Contract Exclusion
CPT®	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Contract Exclusion
CPT®	15877	Suction assisted lipectomy; trunk	Contract Exclusion
CPT®	15878	Suction assisted lipectomy; upper extremity	Contract Exclusion
CPT®	15879	Suction assisted lipectomy; lower extremity	Contract Exclusion
CPT®	19316	Mastopexy	Contract Exclusion

CPT®	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Contract Exclusion
CPT®	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Contract Exclusion
CPT®	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies	Contract Exclusion
CPT®	31587	Laryngoplasty, cricoid split, without graft placement	Contract Exclusion

Attachment II
ICD-10-CM Diagnosis Code Table & Instructions

Code Type	Number	Description	Policy Instructions
The following diagnosis codes are considered medically necessary when applicable criteria have been met.			
ICD 10	F64.0	Transsexualism	
ICD 10	F64.1	Dual role transvestism	Use additional code to identify sex affirmation surgery status (Z87.890)
ICD 10	F64.2	Gender identity disorder of childhood	
ICD 10	F64.8	Other gender identity disorders	
ICD 10	F64.9	Gender identity disorder, unspecified	