| MDwise<br>POLICY AND PROCEDURE | | | |
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| **TITLE: Gender-Affirming Procedures** | | | **POLICY NO: MM 056** |
| **RESPONSIBLE DEPT: Medical Management** | **DATE LAST REVIEWED, REVISED – NS, OR REVISED AND APPROVED: 05/29/2025** | **DATE EFFECTIVE: 11/12/2020** | **PAGE(s) including attachments: 13** |
| **HIP** ☒ | | | **Hoosier Healthwise** ☒ |

## PURPOSE:

This Policy addresses gender affirmation procedures (also known as sex reassignment surgery, gender or sex confirmation surgery, or gender or sex affirmation surgery), which is one treatment option for extreme cases of gender dysphoria, a condition in which a person feels strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. This Policy applies only to the treatment of members/enrollees who are not "minors" as that term is defined and used in IC 25-1-22 and does not authorize a treatment of a minor individual that is prohibited under IC 25-1-22.
Gender affirmation care services may include hormone treatment, counseling, psychotherapy, complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate, genital reconstruction, facial hair removal, and certain facial plastic reconstruction. The interventions will vary from individual to individual; so medical necessity needs to be considered on an individualized basis. The criteria in this policy outline the medical necessity criteria for gender-affirming medical and surgical treatment (GAMST).

The authorization process utilized to receive/facilitate service requests, evaluate, determine, and notify outcome of medical necessity review, and to monitor continued authorization of services, is consistent with the process for other behavioral health and medical services that require authorization and conducted in compliance with the MDwise Medical Management Policies and Procedures.

***Note:*** Intersex individuals are not subject to the criteria in this policy as these cases will be reviewed using InterQual Criteria

## RELATED POLICIES: MM 002, MM 004, MM 001, MM 030

## POLICY:

Policy/Criteria

I. Gender-affirming surgeries are considered medically necessary for members/enrollees when diagnosed with gender dysphoria or gender incongruence per section A. and when meeting the eligibility criteria in section B.

   A. Gender Dysphoria or Gender Incongruence Criteria: Marked and sustained incongruence between the member/enrollee's experienced/expressed gender and assigned gender, as *indicated by two or more* of the following:
      a. Marked incongruence between the member/enrollee's experienced/expressed gender and primary and/or secondary sex characteristics,

b. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender,
c. A strong desire for the primary and/or secondary sex characteristics of the other gender,
d. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender),
e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender),
f. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender),
g. The condition is associated with impairment in social, occupational, or other important areas of functioning.

B. Eligibility criteria, *all* of the following:

a. Capacity to make a fully informed decision (including, but not limited to, awareness of the potential effects of treatment on fertility) and to consent for treatment,
b. If significant medical or mental health concerns are present, they are reasonably well controlled,
c. Other possible causes of apparent gender dysphoria, gender incongruence, or gender diversity have been identified and excluded,
d. Minimum of one written statement with signature recommending gender-affirming medical and surgical treatment (GAMST) from a health care provider competent to independently assess and diagnose gender incongruence,
e. One of the following:
   i. Assessment for GAMST from a provider who meets both of the following: Has experience in or is qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity (e.g., mental health professional, general medical practitioner, nurse, or other qualified health care provider), and is licensed by their statutory body and hold, at a minimum, a master's degree in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated;
   ii. The documented assessment for GAMST meets all of the following: Identifies any mental or physical health conditions that could negatively impact the outcome of GAMST, with risks and benefits discussed, notes the member/enrollee's capacity to understand the effect of GAMST on reproduction and includes a discussion of reproductive options with the member/enrollee prior to the initiation of GAMST;
   iii. Member/enrollee remains stable on their gender affirming hormonal treatment regime (which may include at least six months of hormone treatment or longer if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

C. Gender-affirming surgeries considered medically necessary when meeting above criteria and additional criteria as listed below for specific procedures:
Any of the following:
1. Penectomy
2. Urethroplasty,
3. Mammoplasty,
4. Mastectomy, and the member/enrollee has been assessed for risk factors associated with breast cancer,
5. Clitoroplasty,

6. Vulvoplasty,
7. Labiaplasty,
8. Vaginectomy,
9. Vulvectomy,
10. Scrotoplasty,
11. Testicular prosthesis,
12. Breast augmentation, and the member/enrollee has been assessed for risk factors associated with breast cancer,
13. Phalloplasty,
14. Metoidioplasty,
15. Vaginoplasty,
16. Gonadectomy (i.e., hysterectomy, salpingo-oophorectomy, orchiectomy; at least six months of hormone therapy may be considered prior to procedure, as appropriate for the member/enrollee's goals).
17. Voice modification surgery, therapy, or lessions.

**III.** Revision procedures for affirming gender are **medically necessary** when the revision is required to address complications of a prior gender affirming procedure (wound dehiscence, fistula, chronic pain directly related to the surgery, etc.).

The codes and billing procedures included in this policy are not to be considered an exhaustive list due to frequent coding and billing changes made by the IHCP. The claims payer has the responsibility to review coding and billing related issues impacting claims processing and to implement those changes. If there is a discrepancy between IHCP claims administration information, provider billing issues and MDwise policy, please notify MDwise immediately.

Services provided by a non-contracted, out of network provider without obtaining required prior authorization will be denied for lack of authorization according to MDwise policy and IAC Rules, IHCP policies and bulletins.

**IV.** The following procedures, when used to improve the gender specific appearance of a member/enrollee undergoing gender affirmation are **not medically necessary**, as they are considered cosmetic in nature (not an all-inclusive list):

1. Abdominoplasty,
2. Liposuction,
3. Skin resurfacing,
4. Revision procedures for purposes other than correction of complications.

**V.** Detransition procedures by gender-related hormone intervention, surgical intervention, or both, will be considered for medical necessity on a case-by-case basis.

Benefit and medical necessity criteria are utilized in determining medical appropriateness of services and care setting includes criteria obtained from current nationally recognized commercial resources (InterQual), state (including Indiana Administrative Code) and federal regulations, OMPP/IHCP Manuals, Health Policy, bulletins and banners, RFS, MDwise medical policy and benefit administration policies, and/or approved internally

developed guidelines/protocols. The member's age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable, are considered when applying criteria to the care requested, along with available services of the local delivery system.

All gender reaffirming service requests will be initially sent to the Medical Management nursing leadership for documentation review. Any decision to authorize/not authorize the service as requested based on medical necessity is made by the Medical Director. Medical necessity determinations and notifications are carried out according to MM 02 Medical Necessity Determinations of Proposed Services within the applicable timeframes per **MDwise Policy MM 004** Timeliness of Decision Making and Notification.

**Background**

The World Professional Association for Transgender Health (WPATH), an international professional society is dedicated to promoting the highest level of evidence-based principles for transgender and gender diverse (TGD) individuals. Gender identity is a person's deepest inner sense of being female or male, which for many is established by the age of two through three years. *Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.2 *Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). WPATH guidelines state that gender incongruence is considered a condition with a focus on the TGD person's experienced identity and any need for gender-affirming treatment that arises from this identity, and the focus of gender dysphoria is not on the individual's gender identity, but on any of the distress or discomfort related to being TGD.

Individualized treatment to assist people with gender dysphoria is available and can help to find the gender identity and role that is comfortable for them. Treatment may not involve gender-affirming surgery or body modification.

Treatment may include changes in gender expression and role; hormone therapy ;surgery; and psychotherapy. The WPATH's Standards of Care (SOC) are a series of flexible guidelines for clinical practice published by the society. These guidelines are based on evidence and expert consensus. Version 8 of WPATH's SOC (published in 2022) offers clinical guidance to health care professionals caring for TGD people and are intended to be adaptable to meet the diverse health care needs of this population.

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

1. Identify co-existing mental health or other psychosocial concerns, distinguishing these from gender dysphoria, incongruence, and diversity,
2. Assess capacity to consent for treatment (capacity to consent is required for GAMST assessment);

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

Codes referenced in this clinical policy are from the Current Procedural Terminology (CPT®, a registered trademark of the American Medical Association) are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

The following table lists individual procedure codes including but not limited to, procedures that are covered for gender reassignment. Codes may be billed independently or in combinations. CPT codes that may be considered part of gender-affirming surgery. This code list does not indicate if a procedure is or is not considered medically necessary.

| CPT | Description |
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| 11960 | Insertion of tissue expander(s) for other than breast, including subsequent expansion |
| 11970 | Replacement of tissue expander with permanent prosthesis |
| 14000 | Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less |
| 14001 | Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm |
| 14040 | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less |
| 14041 | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm |
| 15100 | Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) |
| 15101 | Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15120 | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) |

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| 15121 | Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) |
| 15200 | Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less |
| 15570 | Formation of direct or tubed pedicle, with or without transfer; trunk |
| 15574 | Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet |
| 15600 | Delay of flap or sectioning of flap (division and inset); at trunk |
| 15620 | Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet |
| 15757 | Free skin flap with microvascular anastomosis |
| 15758 | Free fascial flap with microvascular anastomosis |
| 15830 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy |
| 17380 | Electrolysis epilation, each 30 minutes |
| 19303 | Mastectomy, simple, complete |
| 19316 | Mastopexy |
| 19324 | Mammaplasty, augmentation; without prosthetic implant |
| 19325 | Mammaplasty, augmentation; with prosthetic implant |
| 19350 | Nipple/areola reconstruction |
| 53410 | Urethroplasty, 1-stage reconstruction of male anterior urethra |
| 53415 | Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra |
| 53420 | Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage |
| 53425 | Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage |
| 53430 | Urethroplasty reconstruction female urethra |
| 53460 | Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure) |
| 54125 | Amputation of penis; complete |
| 54400 | Insertion of penile prosthesis; non-inflatable (semi-rigid) |
| 54401 | Insertion of penile prosthesis; inflatable (self-contained) |
| 54405 | Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir |
| 54406 | Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis |
| 54408 | Repair of component(s) of a multi-component, inflatable penile prosthesis |
| 54410 | Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session |
| 54411 | Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same |

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| | operative session, including irrigation and debridement of infected tissue |
| 54415 | Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis |
| 54416 | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session |
| 54417 | Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue |
| 54520 | Orchiectomy simple with or without testicular prosthesis, scrotal or inguinal approach |
| 54660 | Insertion testicular prosthesis (separate procedure) |
| 54690 | Laparoscopy, surgical; orchiectomy |
| 55175 | Scrotoplasty; simple |
| 55180 | Scrotoplasty; complicated |
| 55970 | Intersex surgery; male to female |
| 55980 | Intersex surgery; female to male |
| 56625 | Vulvectomy simple; complete |
| 56800 | Plastic repair of introitus |
| 56805 | Clitoroplasty intersex state |
| 56810 | Perineoplasty, repair of perineum, nonobstetrical (separate procedure) |
| 57106 | Vaginectomy, partial removal of vaginal wall; |
| 57107 | Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) |
| 57110 | Vaginectomy complete removal vaginal wall |
| 57111 | Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) |
| 57291 | Construction artificial vagina; without graft |
| 57292 | Construction artificial vagina; with graft |
| 57295 | Revision (including removal) of prosthetic vaginal graft; vaginal approach |
| 57296 | Revision (including removal) of prosthetic vaginal graft; open abdominal approach |
| 57335 | Vaginoplasty intersex state |
| 57426 | Revision (including removal) of prosthetic vaginal graft, laparoscopic approach |
| 58150 | Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s) |
| 58260 | Vaginal hysterectomy, for uterus 250 g or less |
| 58262 | Vaginal hysterectomy uterus 250 g or less; with removal of tube(s) and/or ovary (s) |
| 58263 | Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele |
| 58267 | Vaginal hysterectomy, for uterus 250 g or less; with colpourethrocystopexy (Marshall- Marchetti-Krantz type, Pereyra type) with or without endoscopic control |

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| 58270 | Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele |
| 58275 | Vaginal hysterectomy, with total or partial vaginectomy |
| 58285 | Vaginal hysterectomy, radical (Schauta type operation) |
| 58290 | Vaginal hysterectomy, for uterus greater than 250 g |
| 58291 | Vaginal hysterectomy uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58292 | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele |
| 58293 | Vaginal hysterectomy, for uterus greater than 250 g; with colpourethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control |
| 58294 | Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele |
| 58541 | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; |
| 58542 | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
| 58543 | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; |
| 58544 | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58550 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less |
| 58552 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary (s) |
| 58553 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g |
| 58554 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58570 | Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less |
| 58571 | Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
| 58572 | Laparoscopy, surgical, with total hysterectomy for uterus greater than 250 g |
| 58573 | Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58661 | Laparoscopy surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy) |
| 58720 | Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) |
| 58940 | Oophorectomy, partial or total, unilateral or bilateral |
| 58999 | Unlisted procedure, female genital system (nonobstetrical) |
| 64856 | Suture of major peripheral nerve, arm or leg, except sciatic; including transposition |
| 64892 | Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length |
| 64896 | Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length |

**BENEFIT COVERAGE AND RESTRICTIONS:**
Coverage of gender affirming services is subject to the restrictions outlined, and individuals must meet the defined medical necessity criteria, and be documented sufficiently for post payment review if requested.

**BILLING/REIMBURSEMENT**
Contracted MDwise providers will be paid according to their contract for participation in MDwise.

Non-contracted providers will be paid for services covered under this policy in an amount equal to ninety eight percent (98%) of the IHCP fee schedule for medically necessary services for Hoosier Healthwise Members. Providers will be reimbursed for Healthy Indiana Plan covered services at a rate not less than 130% of Medicaid rates if the service does not have a Medicare reimbursement rate

I. When a code is listed as covered on the Medicaid file and states manual payment, MDwise will pay at the percentage listed for this code. If the code is not listed as a covered code the service is denied as not covered.

**CARE MANAGEMENT**
Members with a diagnosis of gender dysphoria seeking gender affirming services are eligible for care management services.

**CONTINUITY OF CARE**
Continuity of care policies and honoring prior authorized services apply to covered services provided by out of network providers**.**

**MEMBER COST SHARING**
Members may incur copayments for services outlined in this policy, in accordance with their HIP 2.0 benefit plans.

## SCOPE:
All staff conducting medical management reviews, claims configuration and reimbursement transportation, and care management on behalf of MDwise members.

**REFERENCES:**


A. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 5th ed.* Arlington, VA: American Psychiatric Publishing; 2013.
B. The World Professional Association for Transgender Health, Inc. (WPATH). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, Version 8. https://www.wpath.org/publications/soc. Published 2022. Accessed May 31,2024.
C. Indiana Laws & Regulations:
D. **MDwise Policy and Procedures: MM 001; MM 002; MM 030**


## MDwise Policy and Procedure Approval

**Policy Owner Name:** Jeffrey Wheeler

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| **Title:** | Chief Medical Director |
| **Date:** | 05/29/2025 |

**History of Policy and Procedure Revisions and Reviews:**

| ***Date*** | ***Action*** | ***Review Committee (if Applicable)*** | ***Notes*** |
|---|---|---|---|
| 11/12/2020 | Issued | Compliance Committee | |
| 06/29/2022 | Reviewed | | |
| 10/31/2022 | Revised | Readiness Review | |
| 11/18/2022 | Approved | | State Readiness Review |
| 03/07/2023 | Reviewed | | |
| 08/09/2024 | Revised | | Revised to reflect the newest WPATH guidelines and State statutes |
| 10/04/2024 | Approved | OMPP | Approval code: DR-09-2024-14467 |
| 10/10/2024 | Revised | Compliance Committee | |
| 04/09/2025 | Revised- NS | | Removed reference to retired policy TR002. |
| 05/29/2025 | Reviewed | | Annual Review |