PHP_7.02	Gender Affirmation Surgery		
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Section:	7.0 Surgery	**Page:**	Page 1 of 17

State Guidelines

Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):

I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
- N/A

II. Department of Health Care Services (DHCS) Provider Manual Guideline:
- Transgender and Gender Diverse Services (transgender)

Below is an excerpt of the guideline language. Please refer to the specific Provider Manual in the link above for the complete guideline.

Gender Affirming Care
Gender affirming care refers to treatment provided to address incongruence between a person's gender assigned at birth and their gender identity. Gender affirming care is a covered Medi-Cal benefit when medically necessary. Requests for gender affirming care should be from specialists experienced in providing culturally competent care to transgender and gender diverse individuals and should use nationally recognized guidelines. One source of clinical guidance for the treatment of gender affirming care is found in the most current "Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health (WPATH)[1] on the WPATH website (www.wpath.org).[1]

Covered Benefits
Nationally recognized medical experts in the field of transgender health care have identified the following core services in providing gender affirming care:
- Mental and behavioral health services
- Hormone therapy
- A variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender, including ancillary services, such as hair removal, incident to those services

Medically necessary covered services are those services that "are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury" (California Code of Regulations [CCR], Title 22, Section 51303). Medical necessity is assessed and services shall be recommended by treating licensed mental health professionals and physicians and surgeons experienced in treating patients with incongruence between their gender identity and gender assigned at birth.

In the case of gender affirming care services, "normal appearance" is determined by referencing the gender with which the recipient identifies. Reconstructive surgery to create a normal appearance for transgender recipients is determined to be medically necessary for the treatment of gender dysphoria on a case-by-case basis.

A service or the frequency of services available to a transgender or gender diverse recipient cannot be categorically limited. All medically necessary services must be provided timely. Limitations and exclusions, medical necessity and reconstructive determinations and/or appropriate utilization management criteria that are non-discriminatory may be applied.

Intersex surgery should not be requested or billed using CPT® code 55970 (intersex surgery; male to female) or CPT code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT coding should be specific for the procedures performed during each operation. A Treatment Authorization Request (TAR) is necessary only for procedures that currently require a TAR. The TAR must establish the need for the procedure as outlined above.

Non-Benefits Coverable with a TAR Override
For benefits or services corresponding to CPT or HCPCS codes that are listed in the *TAR and Non-Benefit: Introduction to List* section of the provider manual, the Primary Surgeon/Provider may submit a TAR demonstrating medical necessity to obtain approval for coverage and reimbursement for an individual Medi-Cal member under this section.

III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
- APL 20-018

Below is an excerpt of the guideline language. Please refer to the specific All Plan Letter in the link above for the complete guideline.

Background:

Nondiscrimination Laws
The Insurance Gender Nondiscrimination Act (IGNA) prohibits Medi-Cal managed care health Plans (MCPs) from discriminating against individuals based on gender, including gender identity or gender expression.[2] The IGNA requires that MCPs provide transgender members with the same level of health care benefits available to non-transgender members.

The Affordable Care Act (ACA) and the implementing regulations prohibit discrimination against transgender individuals eligible for services and require MCPs to treat members in a manner consistent with the member's gender identity. The ACA requires that MCPs provide all members with a common core set of benefits, known as Essential Health Benefits (EHB). Health insurers covering EHBs are prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.[3] Specifically, federal regulations prohibit MCPs from denying or limiting coverage of any health care services that are ordinarily or exclusively available to members of one gender to a transgender member based on the fact that a member's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.[4]

Federal regulations further prohibit MCPs from categorically excluding or limiting coverage for health care services related to gender transition.[5] Federal regulations similarly prohibit categorically restricting the scope of services to a member "solely because of the diagnosis, type of illness, or condition."[6]

MCP Contractual Obligations
MCPs are contractually obligated to provide medically necessary covered services to all members, including transgender members. State law defines "medically necessary" as follows:

(a) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.[7]
(b) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions.[8]

MCPs must also provide reconstructive surgery to all members, including transgender members. The analysis of whether or not a surgery is considered reconstructive surgery is separate and distinct from a medical necessity determination. State law defines reconstructive surgery as "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease…to create a normal appearance to the extent possible."[9] In the case of transgender members, gender dysphoria is treated as a "developmental abnormality"[10] for purposes of the reconstructive statute and "normal" appearance is to be determined by referencing the gender with which the member identifies.[11]

MCPs are not contractually obligated to provide cosmetic surgery. State law defines cosmetic surgery as "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance."[12]

Policy:

Analyzing Transgender Service Requests

MCPs must analyze transgender service requests under both the applicable medical necessity standard for services to treat gender dysphoria and under the statutory criteria for reconstructive surgery. A finding of either "medically necessary to treat gender dysphoria" or "meets the statutory criteria of reconstructive surgery" serves as a separate basis for approving the request.

If the MCP determines that the service is medically necessary to treat the member's gender dysphoria, the MCP must approve the requested service. If the MCP determines the service is not medically necessary to treat gender dysphoria (or if there is insufficient information to establish medical necessity), the MCP must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.

The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member's primary care provider, licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.

When analyzing transgender service requests, MCPs must consider the knowledge and expertise of providers qualified to treat gender dysphoria (including the member's providers) and must use nationally recognized medical/clinical guidelines. One source of clinical guidance for the treatment of gender dysphoria is found in the most current "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health.[1] Clinical guidance and literature regarding appropriate health care for transgender individuals is rapidly developing in light of new research and clinical experience. MCPs must continuously monitor current guidance on transgender health care to ensure consistency with current medical practice.

Nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria: mental health services; psychotherapy; hormone therapy; and a variety of surgical procedures and treatments that bring primary and secondary gender characteristics into conformity with the individual's identified gender.[13] Surgical procedures and treatments that bring secondary gender characteristics into conformity with an individual's identified gender may include, but are not limited to, sex reassignment surgery, facial gender confirmation surgery, body contouring, hair removal, and voice therapy and vocal surgery, if these services are determined to be medically necessary to treat a member's gender dysphoria, or if the services meet the statutory definition of reconstructive surgery.

Policy Statement

Any criteria that are not specifically addressed in the above APL or Provider Manual, please refer to the criteria below.

The STANDARDS OF CARE for the Health of Transgender and Gender Diverse People developed by the World Professional Association for Transgender Health (WPATH) will be used as guidelines when making determinations on Gender Affirmation Surgery and other associated surgical procedures.

Policy Guidelines

The most recent edition of the World Professional Association for Transgender Health (WPATH), Standards of Care (SOC) for the Health of Transgender and Gender Diverse People is used in the formation of the guidelines in this policy.[1]

Cosmetic surgery is distinguished from medically necessary surgery. Cosmetic surgery is performed to alter or reshape normal structures of the body in order to try to further improve appearance. Medically necessary procedures are done to create a normal appearance to the extent possible when structures or features are outside the range of normal for the desired gender.

In interpreting whether a proposed procedure meets the definition of medically necessary, the procedure may be denied as **not medically necessary** under **any** of the following conditions:

- The features or structures to be altered are considered to be within the range of normal for the preferred gender
- The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) quality color photographs, which accurately depicts the extent of the clinical issue or documentation of appropriate sex hormone use
- There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes

Per the current WPATH SOC, only one assessment letter from a qualified healthcare professional is required (as applicable) to recommend gender affirming medical or surgical treatment.[1]

Coding

Note: CPT 19303 (Mastectomy, simple, complete) is for breast cancer/cancer prevention and should not be used to bill for reduction mammaplasty for Female-to-Male Intersex Surgery. A more appropriate code to report on this service is CPT 19318 (Breast reduction), as it includes the work that is necessary to create a more aesthetically pleasing result. Additionally, CPT 19350 (Nipple/areola reconstruction) is not recommended for nipple reconstruction in gender affirmation surgery.

Coding
See the Codes table for details.

Description

Gender affirmation surgery is a term for surgical procedures by which an individual's physical appearance and function of their existing sexual characteristics are altered to resemble that of the other sex (i.e., either female-to-male [transgender man] or male-to-female [transgender woman]). Gender affirmation surgery may be performed for an intersex condition (i.e., born with sex characteristics of an indeterminate sex), those who identify as eunuchs (assigned males at birth who wish to remove masculine physical features, masculine genitals, or genital functioning or those who have had their testicles surgically removed or made nonfunctional), or as a treatment option for gender dysphoria. This medical policy addresses gender affirmation surgery for the treatment of gender dysphoria.

Related Policies

- Reconstructive Services

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

State:
The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following (see also Blue Shield of California Promise Health Plan Medical Policy: Reconstructive Services):

- Create a normal appearance to the extent possible
- Improve function

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic

group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Gender affirmation surgery is a means of transitioning the body to a different gender through surgical alteration of the body (transgender). Men who are transitioning to female are known as male to female (MTF) or transgender women, and women who are transitioning to male are known as female to male (FTM) or transgender men. Gender affirmation surgery involves genital reconstruction and other additional procedures, proposed as part of a multifactor treatment approach for individuals with gender dysphoria. The surgery is intended to be a permanent change to the individual's identity; therefore, comprehensive evaluations and ongoing medical and psychosocial therapy by qualified mental health and medical professionals are required to determine whether surgery is the appropriate option for the individual.

Transgender is a broad umbrella term that includes people whose gender identity and/or gender expression differs from their assigned sex at birth. The World Professional Association for Transgender Health (WPATH), Standards of Care (SOC) for the Health of Transgender and Gender Diverse People**,** "use the phrase transgender and gender diverse (TGD) to be as broad and comprehensive as possible in describing members of the many varied communities globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth."[1]

Gender Dysphoria

Gender dysphoria describes a condition that results in intense discomfort and distress that is caused by a discrepancy between an individual's gender identity and that individual's sex assigned at birth, including the associated gender role and/or primary and secondary sex characteristics.[1,14-15] The "critical element of gender dysphoria is the presence of clinically significant distress associated with the condition."[10]

Therapeutic Options for Gender Dysphoria

According to WPATH[1], a variety of therapeutic options can be considered for individuals seeking care for gender dysphoria. These options include:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity, i.e., social transition)
- Hormone therapy to feminize or masculinize the body
- Surgery to change primary and/or secondary characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; enhancing social and peer support; improving body image; or promoting resilience

Mental Health Professionals

Mental health professionals play an important role in assisting individuals with gender dysphoria in providing counseling of treatment options, and psychotherapy (as needed). Clinical training and knowledge about transgender and gender diverse people, and the assessment and treatment of gender dysphoria is required. Qualified mental health professionals should be trained to assess, recognize, diagnose, and treat (or refer to treatment for) coexisting mental health problems.[1] The presence of coexisting mental health concerns does not necessarily preclude possible changes in gender role or access to hormonal therapy or surgery; rather these concerns need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria. Additionally, individuals should

be assessed for their ability to provide educated and informed consent for medical treatments. After evaluation, the mental health professional should provide documentation and formal recommendations to medical and surgical specialists (as applicable).

Social Transition

Health care professionals assessing transgender and gender diverse individuals for gender-affirming medical treatments should discuss social transition with each individual. While social transition can benefit many, not all TGD people wish to or are able to socially transition. Assessments must respect diverse gender identities and presentations, including nonbinary roles shaped by cultural and individual factors. Some may pursue treatment without social transition; in these cases, further assessment is necessary, especially before surgical interventions, to evaluate the request and inform individuals about potential outcomes.[1]

Hormone Therapy

When indicated, hormone therapy plays an important role in the gender transition process. Hormone therapy is a recommended criterion for some, but not all, surgical treatments of gender dysphoria (e.g., mastectomy or creation of a male chest).

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. Feminizing/masculinizing hormonal interventions are not without risk for complications, including irreversible physical changes. 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 gender affirming hormone therapy, including both benefits and risks. Ongoing medical management, including physical examination and laboratory evaluation studies to manage dosage, side effects, etc., is required. Lifelong hormone maintenance is usually recommended.

Gender Affirmation Surgery

Per the current edition of WPATH SOC, the criteria for surgery in adults is as follows:

a. "Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
d. Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
e. Other possible causes of apparent gender incongruence have been identified and excluded;
f. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed;
g. Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).*
*These were graded as suggested criteria"[1]

Per the current edition of WPATH SOC, the criteria for surgery in adolescents is as follows:

a. "Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;

d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the
g. desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated."[1]

Feminizing Surgeries (Male-to-Female)
Feminizing surgeries for male-to-female (MTF) patients are intended to reshape a male body into the appearance of and, to the extent possible, the function of a female body; all of which require skilled surgery and postoperative care.[1]

- Orchiectomy (removal of the testicles)
- Penectomy (removal of the penis)
- Vaginoplasty (creation of vagina)
- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Vulvoplasty (including colovaginoplasty, labiaplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy)
- Gender-affirming breast surgery
- Facial feminization surgery (including chondrolaryngoplasty/vocal cord surgery)
- Body contouring procedures

Masculinizing Surgeries (Female-to-Male)
Masculinizing surgeries for female-to-male (FTM) patients are intended to reshape the female body into the appearance of a male body.[1] The gender affirmation surgeries that may be performed for FTM patients include:

- Mastectomy (removal of the breast, and nipple tattooing)
- Reduction mammoplasty (reduction of breast size)
- Hysterectomy (removal of the uterus)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Vaginectomy (removal of vagina)
- Metoidioplasty (creation of micro-penis, using the clitoris tissue)
- Phalloplasty (skin graft is used to create a penis, with or without urethra)
- Urethroplasty (creation of urethra within the penis)
- Scrotoplasty (creation of scrotum)
- Placement of a testicular prostheses (the labia majora is dissected forming cavities allowing for implantation of artificial testes (testicular implant)
- Facial masculinization surgery
- Body contouring procedures

Gender-affirming surgery (GAS) encompasses a range of procedures for transgender and gender diverse individuals assigned male or female at birth. Evidence supports the benefits of GAS for appropriately selected patients, with most complications being minor or manageable in outpatient settings. Surgeons must understand the indications and timing for GAS, particularly for adolescents. A shared decision-making process is vital, involving multidisciplinary input, understanding patient goals, discussing risks and benefits, and planning aftercare. Proper postoperative care is essential for good outcomes and patients should be well informed about their recovery needs. Surgeons should remain accessible for follow-up and referrals as needed, ensuring ongoing medical and psychosocial

support. Due to growing demand for GAS, there is a need for continued surgeon education, outcome monitoring, and specialized training.[1]

Summary of Evidence

Gender affirmation surgical treatments for gender dysphoria are not merely another set of elective procedures, but can present with certain medical and psychological risks, some of which are irreversible; therefore, these surgical treatments require a cohesive multidisciplinary specialty team including physicians, surgeons, and mental health providers in order to provide the best results and benefits for the individual with gender dysphoria. An individual's sexual satisfaction after the surgery can vary depending on the success of the surgical affirmation technique and the psychological stability of the individual.

Gender affirmation surgery has been accepted as a treatment option for individuals who satisfy the formal diagnostic criteria for gender dysphoria and undergo hormone therapy (as applicable) prior to surgery, when in accordance with the WPATH SOC medically necessary criteria.[1] While additional surgeries have been proposed for improving appearance (i.e., body feminization or masculinization); in general, if clinical review determines the transgender individual's appearance is within the wide range of appearance variation for people of the desired gender, these enhancement surgeries would not be considered medically necessary.[16]

Supplemental Information

Practice Guidelines and Position Statements

The most recent edition of World Professional Association for Transgender Health (WPATH) has established medical necessity criteria through publication of the "Standards of Care for the Health of Transgender and Gender Diverse People".[1] This document is widely accepted as the definitive document in the area of gender dysphoria treatment and has been adopted in several countries as the standard of care. The WPATH recommendations for the standards of care are based on scientific evidence and expert consensus.

References

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14. Fisk NM. Editorial: Gender dysphoria syndrome – the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. Western Journal of Medicine. 1974; 120(5), 386-91.
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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Comorbidities
  - Reason for procedure/therapy
  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Treatment plan (i.e., surgical intervention)
- Consultation and medical clearance report(s), when applicable
- Radiology report(s) and interpretation (i.e., MRI, CT, discogram), when applicable
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable
- Quality color photographs (as applicable)

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed

- Procedure report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
	11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
	11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
	11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
	11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
	11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	11970	Replacement of tissue expander with permanent implant
	11971	Removal of tissue expander without insertion of implant
	15770	Graft; derma-fat-fascia
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	Punch graft for hair transplant; more than 15 punch grafts
	15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)
	15824	Rhytidectomy; forehead
	15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
	15826	Rhytidectomy; glabellar frown lines
	15828	Rhytidectomy; cheek, chin, and neck
	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad

Type	Code	Description
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19300	Mastectomy for gynecomastia
	19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy);
	19303	Mastectomy, simple, complete
	19316	Mastopexy
	19318	Breast reduction
	19325	Breast augmentation with implant
	19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
	19342	Insertion or replacement of breast implant on separate day from mastectomy
	19350	Nipple/areola reconstruction
	19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
	21087	Impression and custom preparation; nasal prosthesis
	21088	Impression and custom preparation; facial prosthesis
	21089	Unlisted maxillofacial prosthetic procedure
	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	Genioplasty; sliding osteotomy, single piece
	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
	21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
	21125	Augmentation, mandibular body or angle; prosthetic material
	21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
	21137	Reduction forehead; contouring only
	21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
	21193	Reduction forehead; contouring and setback of anterior frontal sinus wall
	21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
	21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
	21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
	21209	Osteoplasty, facial bones; reduction
	21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
	21270	Malar augmentation, prosthetic material
	21299	Unlisted craniofacial and maxillofacial procedure

Type	Code	Description
	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	Rhinoplasty, primary; including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
	31587	Laryngoplasty, cricoid split, without graft placement
	31599	Unlisted procedure, larynx
	31750	Tracheoplasty; cervical
	53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
	53430	Urethroplasty, reconstruction of female urethra
	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 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 (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
	54660	Insertion of testicular prosthesis (separate procedure)
	54690	Laparoscopy, surgical; orchiectomy
	55150	Resection of scrotum
	55175	Scrotoplasty; simple
	55180	Scrotoplasty; complicated
	55970	Intersex surgery; male to female
	55980	Intersex surgery; female to male
	56620	Vulvectomy simple; partial
	56625	Vulvectomy simple; complete
	56800	Plastic repair of introitus
	56805	Clitoroplasty for intersex state

Type	Code	Description
	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 of vaginal wall;
	57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
	57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
	57335	Vaginoplasty for intersex state
	57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
	57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
	58260	Vaginal hysterectomy, for uterus 250 g or less;
	58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
	58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
	58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
	58275	Vaginal hysterectomy, with total or partial vaginectomy;
	58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
	58285	Vaginal hysterectomy, radical (Schauta type operation)
	58290	Vaginal hysterectomy, for uterus greater than 250 g;
	58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
	58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
	58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
	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)

Type	Code	Description
	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)
	58555	Hysteroscopy, diagnostic (separate procedure)
	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;
	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
HCPCS	C1813	Prosthesis, penile, inflatable
	C2622	Prosthesis, penile, noninflatable

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/01/2025	New policy.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

In making a determination that any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply is "experimental or investigational" by the Plan, the Plan shall refer to evidence from the national medical community, which may include one or more of the following sources:

1. Evidence from national medical organizations, such as the National Centers of Health Service Research.
2. Peer-reviewed medical and scientific literature.
3. Publications from organizations, such as the American Medical Association (AMA).
4. Professionals, specialists, and experts.
5. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment.
6. An expert physician panel selected by one of two organizations, the Managed Care Ombudsman Program of the Medical Care Management Corporation or the Department of Managed Health Care.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.