Clinical Policy: Gender Transitioning and Gender Reassignment Procedures and Treatments

Reference Number: TX.CP.MP.595
Date of Last Revision: 09/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Background

Texas law prohibits Medicaid coverage of gender-affirming care for transgender youth. The law also prevents transgender people under 18 from accessing hormone therapies, puberty blockers, and transition surgeries. In June 2024, the Texas Supreme Court upheld the ban on gender-affirming care for minors, rejecting pleas from parents that it violated their right to seek medical care for their transgender children.

Policy/Criteria

It is the policy of Superior HealthPlan that gender-affirming care for Medicaid children under the age of 18 is not a Texas Medicaid nor Children's Health Insurance Program (CHIP) covered benefit.

For the purpose of transitioning a child's biological sex as determined by the sex organs, chromosomes, and endogenous profiles of the child or affirming the child's perception of the child's sex if that perception is inconsistent with the child's biological sex, a physician or health care provider may not knowingly: (1) perform a surgery that sterilizes the child, including: castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, vaginoplasty; or (2) perform a mastectomy.

Coding Implications

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CPT Code Table 1: Procedure codes denied as not a covered benefit when billed with diagnosis codes for gender dysphoria listed in the ICD-10 Table 1 below.

Procedure Code	Procedure Code Description
19325	BREAST AUGMENTATION WITH IMPLANT
54125	AMPUTATION OF PENIS; COMPLETE
54520	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR WITHOUT TESTICULAR PROSTHESIS, SCROTAL OR INGUINAL

Procedure Code	Procedure Code Description
	APPROACH
54690	LAPAROSCOPY, SURGICAL; ORCHIECTOMY
55866	LAPAROSCOPY, SURGICAL PROSTATECTOMY, RETROPUBIC RADICAL, INCLUDING NERVE SPARING, INCLUDES ROBOTIC ASSISTANCE, WHEN PERFORMED
55970	INTERSEX SURGERY; MALE TO FEMALE
56800	PLASTIC REPAIR OF INTROITUS
56805	CLITOROPLASTY FOR INTERSEX STATE
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
19303	MASTECTOMY, SIMPLE, COMPLETE
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 OF FEMALE URETHRA
54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)
55175	SCROTOPLASTY; SIMPLE
55180	SCROTOPLASTY; COMPLICATED
55980	INTERSEX SURGERY; FEMALE TO MALE
56625	VULVECTOMY SIMPLE; COMPLETE
57106	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL;
57110	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL;
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)

Procedure Code	Procedure Code Description
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)
58275	VAGINAL HYSTERECTOMY, WITH TOTAL OR PARTIAL VAGINECTOMY;
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)
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)
58720	SALPINGO-OOPHORECTOMY, COMPLETE OR PARTIAL, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)
11950	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1 CC OR LESS

Procedure Code	Procedure Code Description
11951	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC
11952	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC
11954	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); OVER 10.0 CC
15769	GRAFTING OF AUTOLOGOUS SOFT TISSUE, OTHER, HARVESTED BY DIRECT EXCISION (EG, FAT, DERMIS, FASCIA)
15771	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; 50 CC OR LESS INJECTATE
15772	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 50 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15773	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, AND/OR FEET; 25 CC OR LESS INJECTATE
15774	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, AND/OR FEET; EACH ADDITIONAL 25 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS
15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS
15820	BLEPHAROPLASTY, LOWER EYELID;
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
15822	BLEPHAROPLASTY, UPPER EYELID;
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID
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
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE

Procedure Code	Procedure Code Description
	(INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
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
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
19316	MASTOPEXY
19350	NIPPLE/AREOLA RECONSTRUCTION
21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, 2 OR MORE OSTEOTOMIES (EG, 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)

Procedure Code	Procedure Code Description
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION
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)

ICD-10-CM Code Table 1: Diagnoses for gender dysphoria

ICD 10 CM Code	Description
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy creation and Approval	09/2024	
Annual Review.	09/2025	09/2025

References

1. 88th Legislature, Texas Senate Bill 14 passed on 06/02/23 and effective on 09/01/2023, relating to prohibitions on the provision to certain children of procedures and treatments for gender transitioning, gender reassignment, or gender dysphoria and on the use of public money or public assistance to provide those procedures and treatments.

Important Reminders This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the

administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid or CHIP coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid and CHIP coverage provisions take precedence.