Medicare Medical Policy

Gender Affirming Surgical Interventions

MEDICARE MEDICAL POLICY NUMBER: 402

Effective Date: 12/1/2025

Last Review Date: 11/2025

Next Annual Review: 11/2026

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Notes:

- This policy only addresses surgical interventions for gender dysphoria/incongruence. It does **not** address hormonal treatments or fertility preservation.
- State mandates do not apply to Medicare Advantage plans.

Service	Medicare Guidelines
Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below)* • **Medicare Coverage Manuals:** Medicare does not have criteria for gender affirming surgical procedures in a coverage manual. • **National Coverage Determination (NCD):** From August 1989 to May 2014, Medicare had a "Transsexual Surgery" NCD, which considered gender reassignment surgery to be experimental and non-covered. As of May 2014, it was determined that the NCD denying coverage for all gender reassignment surgery was invalid and coverage became left to local Medicare Administrative Contractor (MAC) discretion. • **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, only one MAC has an LCA for gender reassignment and gender dysphoria treatments (Palmetto GBA; LCA A53793); however, this MAC is **not** the MAC for the plan's service area, and therefore, this LCA is not used. According to the Noridian J-F LCD for *Plastic Surgery* (L35163), "All coverage determinations for transgender surgery are currently handled by individual consideration on a case-by-case review with particular consideration of the World Professional Association for Transgender Health (WPATH) Standards of Care as interpreted through the various Medicare statutes, rules, regulations, and Manual instructions." • Therefore, in the absence of established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making. In this case, Medicare coverage criteria are considered "not fully established" as defined under CFR § 422.101(6)(i)(B) as the available Medicare coverage policies provide flexibility for coverage decisions beyond the LCD (there is no NCD and the Noridian LCD L35163 specifically states it does not apply to transgender	

surgery, but that those decisions are made on a case-by-case basis). Since the plan's internal coverage criteria are based on WPATH guidelines, the Company's internal coverage criteria is applied. • ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*	
Gender Affirming Surgical Interventions *Use of Skin Substitutes in Gender Affirming Surgical Interventions*	Company medical policy for Gender Affirming Surgical Interventions I. These services may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. These services are considered **not medically necessary** for Medicare when the Company medical policy criteria are not met. *See Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

- Cosmetic and Reconstructive Procedures, MP232
- Breast Reconstructive Surgery, Implant Management, and Reduction Mammoplasty, MP523
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift, MP225
- Rhinoplasty and Other Nasal Surgeries, MP247
- Skin and Tissue Substitutes, MP371
- Surgical Treatment for Skin Redundancy, MP259

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

The documentation below is required for gender affirming surgery. If any of these items are not submitted, requests will be delayed until the additional documentation is received.

- Clinical notes submitted by the operating surgeon; and
- One of the following:
  - For adults (18 years and older): one (1) letter of assessment from a health care professional (see Policy Guidelines) who has competencies in the assessment of transgender and gender diverse people.
  - For adolescents (defined by WPATH as the start of puberty until the legal age of majority [age 18 in the United States]): one (1) letter of assessment from a member of the

multidisciplinary team (see Policy Guidelines). The letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals.

BACKGROUND, MEDICARE COVERAGE AND MEDICAL NECESSITY

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*.

From August 1989 to May 2014, Medicare had a "Transsexual Surgery" NCD, which considered gender reassignment surgery to be experimental and non-covered.

However, as of May 2014, it was determined that the NCD denying coverage for all gender reassignment surgery was invalid and retired. Coverage was then left to local Medicare contractor (MAC) discretion. *(Department of Health and Human Services, DEPARTMENTAL APPEALS BOARD, Appellate Division, NCD 140.3, Transsexual Surgery, Docket No. A-13-87, Decision No. 2576, May 30, 2014)*

In 2016, CMS published a National Coverage Determination (NCD) regarding Gender Dysphoria and Gender Reassignment Surgery (140.9), which stated:

> "The Centers for Medicare & Medicaid Coverage (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery. Effective August 30, 2016, after examining the medical evidence, CMS determined that no national coverage determination (NCD) is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria. In the absence of an NCD, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis."[1]

The local MAC for the health plan – Noridian – states "All coverage determinations for transgender surgery are currently handled by individual consideration on a case by case review with particular consideration of the World Professional Association for Transgender Health (WPATH) Standards of Care as interpreted through the various Medicare statutes, rules, regulations, and Manual instructions." *(LCD for Plastic Surgery [L35163]).*[2]

Since the Plan's Company medical policy is based on WPATH Standards of Care, these policy criteria may be used for Medicare Plan members. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing

clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes and treatment guidelines developed by specialty organizations for policy development.

GENDER AFFIRMING SURGICAL PROCEDURES

The WPATH Standard of Care (SOC) guidelines list gender-affirming surgical procedures (see below), noting the following:

> "As the field's understanding of the many facets of gender incongruence expands, and as technology develops which allows for additional treatments, it is imperative to understand this list is not intended to be exhaustive. This is particularly important given the often lengthy time periods between updates to the SOC, during which evolutions in understanding and treatment modalities may occur."

Table 1: Gender-Affirming Surgical Procedures

Category	Specific Procedures
Facial Surgery	• Brow reduction • Brow augmentation • Brow lift • Hair line advancement and/or hair transplant • Facelift/mid-face lift (following alteration of the underlying skeletal structures) • Blepharoplasty • Platysmaplasty • Rhinoplasty (+/- fillers) • Cheek implant • Cheek lipofilling • Upper lip shortening • Lip augmentation (includes autologous and non-autologous) • Lower jaw reduction of mandibular angle • Chin reshaping (osteoplastic, alloplastic (implant-based)) • Chondrolaryngoplasty/vocal cord surgery
Breast/Chest Surgery	• Mastectomy with nipple-areola reservation/reconstruction as determined medically necessary for the specific patient • Mastectomy without nipple-areola. reservation/reconstruction as determined medically necessary for the specific patient. • Liposuction • Breast reconstruction (augmentation) ○ Implant and/or tissue expander

	○ Autologous (includes flap-based and lipofilling)
Genital Surgery	• Phalloplasty (with/without scrotoplasty) ○ With/without urethral lengthening ○ With/without prosthesis (penile and/or testicular) ○ With/without colpectomy/colpocleisis • Metoidioplasty (with/without scrotoplasty) ○ With/without urethral lengthening ○ With/without prosthesis (penile and/or testicular) ○ With/without colpectomy/colpocleisis • Vaginoplasty (inversion, peritoneal, intestinal) ○ May include retention of penis and/or testicle • Vulvoplasty ○ May include procedures described as "flat front"
Gonadectomy	• Orchiectomy • Hysterectomy and/or salpingo-oophorectomy
Additional Procedures	• Hair removal: Hair removal from the face, body, and genital areas for gender • affirmation or as part of a preoperative preparation process. ○ Electrolysis ○ Laser epilation • Tattoo (i.e., nipple-areola) • Uterine transplantation • Penile transplantation

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

STATE MANDATES

State mandates do **not** apply to Medicare Advantage plans.[3]

BILLING GUIDELINES AND CODING

GENERAL

There is no specific code for some services addressed by this policy. Therefore, an unlisted code may be necessary to bill for the following procedures: laser hair removal, metoidioplasty, phalloplasty.

CPT 19303 describes total removal of ipsilateral breast tissue with or without removal of skin and/or nipples (e.g., nipple-sparing), **for treatment or prevention of breast cancer**. Therefore, 19303 is not appropriate to bill for reduction mammaplasty for female to male (transmasculine) gender affirmation

surgery. For breast tissue removed for breast-size reduction for other than gynecomastia, use 19318. Note that CPT code 19350 is a component of CPT code 19318 and may not be billed when both procedures are performed on the same breast.

CODES*		
Note: • The following codes do not require prior authorization when billed with diagnosis codes F64.0, F64.1, F64.8, or F64.9. Some codes may be non-covered for other diagnosis codes, or prior authorization may be required for other diagnoses, and other medical policies may apply to services when rendered for indications other than gender dysphoria/incongruence. Please refer to the "Prior Authorization" and "Non-Covered and Limited Services" code lists for further information.		
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 (eg, collagen); 1cc or less
	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
	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 injectable
	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)
	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
	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)
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	Punch graft for hair transplant; more than 15 punch grafts
	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
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure)
	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
	19304	Mastectomy, subcutaneous
	19316	Mastopexy
	19318	Reduction mammaplasty
	19325	Mammaplasty, augmentation; with prosthetic implant
	19328	Removal of intact mammary implant
	19330	Removal of mammary implant material
	19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
	19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
	19364	Breast reconstruction with free flap
	19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
	19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
	19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
	19370	Open periprosthetic capsulotomy, breast
	19371	Periprosthetic capsulectomy, breast
	19380	Revision of reconstructed breast
	19396	Preparation of moulage for custom breast implant
	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)
	21137	Reduction forehead; contouring only

	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
	21740	Reconstructive repair of pectus excavatum or carinatum; open
	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
	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)
	53430	Reconstruction of urethra
	54120	Amputation of penis; partial
	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
	54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis, same operative session
	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
	57106	Vaginectomy, partial removal of vaginal wall
	57110	Vaginectomy, complete removal of vaginal wall
	57291	Construction of artificial vagina, without graft
	57292	Construction of artificial vagina, with graft
	57335	Vaginoplasty for intersex state
	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)

	58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
	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
	58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
	58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
	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)
	58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), 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 tub e(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)
	55899	Unlisted procedure, male genital system
	58999	Unlisted procedure, female genital system (nonobstetrical)
	67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
	67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)

	67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
	67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
	67999	Unlisted procedure, eyelids
	69399	Unlisted procedure, external ear
	96999	Unlisted special dermatological service or procedure
HCPCS	C1789	Prosthesis, breast (implantable)
	C1813	Prosthesis, penile, inflatable
	C2622	Prosthesis, penile, non-inflatable
	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome
	L8600	Implantable breast prosthesis, silicone or equal

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9). https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=368. Published 2017. Accessed 9/26/2025.
2. Noridian Healthcare Solutions. Local Coverage Determination: Plastic Surgery (L35163). https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35163. Published 2017. Accessed 9/26/2025.
3. CMS. Medicare Managed Care Manual, Chapter 10 - MA Organization Compliance with State Law and Preemption by Federal Law, §30.1 – General; Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c10.pdf. Accessed 9/26/2025.
4. CMS. MLN Matters® Number. #9981: Gender dysphoria and gender reassignment. [CMS Web site]. Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/mm9981.pdf. Published 04/04/2017. Accessed 9/26/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
12/2023	New Medicare Advantage medical policy
1/2024	Interim update, add codes for punch graft hair transplantation and rhytidectomy
8/7/2024	Update coding appropriate for gender affirming surgical breast procedures
12/2024	Annual review; no change to criteria (10/23/2025: Replaced L37020 with L35163 due to Noridian JF consolidation with JE LCD policies)
12/2025	Annual review; no change to criteria