Medical Coverage Policy | Gender Affirming Care

EFFECTIVE DATE: 01|01|2024
POLICY LAST REVIEWED: 04|01|2026

OVERVIEW
This policy documents the coverage and guidelines for Gender Affirming Care (GAC) applicable to Medicare Advantage Plans and Commercial Products. 679

MEDICAL CRITERIA
None

PRIOR AUTHORIZATION
Prior authorization is required for Medicare Advantage Plans and recommended for Commercial Products for all services in this policy to determine member eligibility. See Eligibility Criteria in the Policy Statement below.

Some services identified with an asterisk in the Policy Statement may also appear in other policies as needing prior authorization to determine medical necessity. However, when these services are filed for a member who has met the Eligibility Criteria below, and who has a benefit for gender affirming care, and when the service is filed for the purpose of gender affirming care with an ICD-10-CM diagnosis code identified in the Coding section below, the service does not require/need prior authorization to determine medical necessity.

The Prior Authorization of Services, Treatments or Procedures policy in the Related Policies section below can be consulted for a listing of procedure codes that are reviewed for medical necessity for diagnoses other than gender dysphoria.

POLICY STATEMENT
Medicare Advantage Plans and Commercial Products
Prior Authorization is required for Medicare Advantage Plans and recommended for Commercial Products to determine if the member is eligible for coverage.

Eligibility Criteria: Members are eligible for gender affirming care services when the documentation submitted confirms that:

- The member has been diagnosed with gender dysphoria
- The member has successfully lived and worked within a gender role that is congruent with their gender identity full-time for at least 12 months.

Services that Require Use of an Unlisted CPT Code
There may not be specific CPT codes for some services addressed in this policy. Please follow claim filing instructions found in the Unlisted Procedures Payment Policy for submission of services filed with Unlisted CPT Codes. Member benefits must be verified/referenced for applicable surgery/gender affirming care benefits/exclusions/coverage. Benefit coverage for gender affirming care services is determined by the member specific benefit plan document.

Surgical Treatment for Gender Affirming Care
In plans that include a benefit for gender affirming care and when all of the eligibility criteria above are met, the following surgeries are covered:

- Breast Augmentation

Note: Augmentation mammoplasty (including breast prosthesis if necessary) if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role.

- Breast reconstruction
- Clitoroplasty
- Colovaginoplasty
- Colpectomy/Vaginectomy
- Facial Surgery*
- Hair Removal/Transplant*
- Hysterectomy
- Labiaplasty
- Lipoplasty*
- Mastectomy
- Metoidioplasty
- Orchiectomy
- Penectomy
- Phalloplasty
- Reduction mammoplasty
- Salpingo-oophorectomy
- Scrotoplasty
- Testicular implants
- Trachea shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage (CPT Code 31899)
- Urethroplasty
- Vaginoplasty
- Vocal Cord Surgery*

* These services may be covered without additional medical necessity review when:

- the eligibility criteria above are met, AND
- performed for the purpose of gender affirming care, AND
- filed with an ICD-10-CM diagnosis code for gender dysphoria (see Coding Section), AND
- Gender Affirming Care is a covered benefit under the member's plan.

Hair Removal

Hair removal procedures may be covered in the following circumstances:

- To treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure, or
- When filed with one of the ICD-10-CM diagnosis codes for gender dysphoria; see Coding section.

Hormone Therapy

Hormone Therapy is not addressed in this policy but may be subject to prior authorization. Please refer to the Prior Authorization of Drugs policy and/or the applicable BCBSRI Pharmacy Program Formulary

Medicare Advantage Plans

Procedures identified in this policy are covered under the applicable conditions in those plans that include a benefit for gender affirming care. Coding instructions outlined must be followed to ensure correct claims processing.

For services related to Infertility and Gender Affirming Care, please refer to the Infertility Services policy in the Related Policies section.

Commercial Products
Procedures identified in this policy are covered under the applicable conditions in those plans that include a benefit for gender affirming care. Coding instructions outlined must be followed to ensure correct claims processing.

For services related to fertility and Gender Affirming Care, please refer to the Infertility Services policy in the Related Policies section. Please note, some plans have customized benefits for coverage. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet to determine whether the member's plan has customized benefit coverage.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable surgery/gender affirming care benefits/coverage.

Inclusion of a service in this policy does not guarantee coverage of the service requested. Not all services addressed in this policy may be covered by all plans depending on group-specific benefits and exclusions. Benefit coverage for health services is determined by the member specific benefit plan document. Please refer to the member contract language to determine if the member's plan includes benefits for these services.

CODING

Medicare Advantage Plans and Commercial Products
The following CPT codes may be covered if the eligibility criteria above are met, and if Gender Affirming Care is a covered benefit under the member's plan, when performed for the purpose of gender affirming care:

19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303 Mastectomy, simple, complete
19316 Mastopexy
19318 Breast Reduction
19325 Breast augmentation with implant
19350 Nipple/areola reconstruction
31899 Unlisted procedure, trachea, bronchi
53430 Urethroplasty, reconstruction of female urethra
54125 Amputation of penis; complete
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
55175 Scrotoplasty; simple
55180 Scrotoplasty; complicated
55899 Unlisted procedure, male genital system
56625 Vulvectomy simple; complete
56800 Plastic repair of introitus
56805 Clitoroplasty for 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 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
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); 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)
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)
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)
58999 Unlisted procedure, female genital system (nonobstetrical)

The CPT procedure codes identified below may be covered when:

- the eligibility criteria above are met, AND
- performed for the purpose of gender affirming care, AND
- filed with one of the following ICD-10-CM diagnosis codes as **primary**, AND
- Gender Affirming Care is a covered benefit under the member's plan.

ICD-10-CM Diagnosis Codes – must be filed as primary diagnosis for coverage of gender affirming care services.

F64.0
F64.1
F64.2
F64.8
F64.9
Z87.890

CPT Procedure Codes

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); 1 cc 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
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
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
15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk
15738 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15750 Flap; neurovascular pedicle
15757 Free skin flap with microvascular anastomosis
15758 Free fascial flap with microvascular anastomosis
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
15780 Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781 Dermabrasion; segmental, face
15782 Dermabrasion; regional, other than face
15783 Dermabrasion; superficial, any site (eg, tattoo removal)
15786 Abrasion; single lesion (eg, keratosis, scar)
15787 Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788 Chemical peel, facial; epidermal
15789 Chemical peel, facial; dermal
15792 Chemical peel, nonfacial; epidermal
15793 Chemical peel, nonfacial; dermal
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 (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
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
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)
21137 Reduction forehead; contouring only
21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 Reduction forehead; contouring and setback of anterior frontal sinus wall
21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179 Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180 Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
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
21499 Unlisted musculoskeletal procedure, head
21899 Unlisted procedure, neck or thorax
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)
31599 Unlisted procedure, larynx
31899 Unlisted procedure, trachea, bronchi
40500 Vermilionectomy (lip shave), with mucosal advancement
40510 Excision of lip; transverse wedge excision with primary closure
40520 Excision of lip; V-excision with primary direct linear closure
40525 Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)
40527 Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Hair Removal
To ensure correct claims processing, claims for hair removal should be filed with the following CPT codes and an ICD-10-CM code above when applicable:
Electrolysis:
17380 Electrolysis epilation, each 30 minutes
Laser Hair Removal:
17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue

Services that Require Use of an Unlisted CPT Code
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The following CPT codes are not to be used for pricing or claims processing, as they are not specific to the individual procedure being performed. Claims for services addressed in this policy should be filed with specific procedure codes above.
55970 Intersex surgery; male to female
55980 Intersex surgery; female to male

RELATED POLICIES
Cosmetic Services and Procedures
Expanded Fertility Services
Infertility Services
Non-Reimbursable Health Service Codes
Prior Authorization of Drugs
Prior Authorization of Services, Treatments or Procedures
Surgical Treatments for Lymphedema & Lipedema
Unlisted Procedures

PUBLISHED
Provider Update, June 2026
Provider Update, September 2025
Provider Update, November 2024
Provider Update, November 2023
Provider Update, November 2022

REFERENCES
Not applicable

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