Health Plan of Nevada
A UnitedHealthcare Company

United Healthcare

GENDER REASSIGNMENT SERVICES

Protocol: MP2023001
Effective Date: 06/04/2025

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INSTRUCTIONS FOR USE
This medical policy provides assistance in interpreting UnitedHealthcare Medicaid benefit plans. When deciding coverage, the member specific benefit plan document or state guidance must be referenced. The terms of the member specific benefit plan [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this medical policy is based. In the event of a conflict, the member specific benefit plan supersedes this medical policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this medical policy. Other policies and guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its policies and guidelines as necessary. This medical policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use nationally recognized clinical guidelines such as MCG® or Interqual® to assist us in administering health benefits. These guidelines are intended to be used in coordination with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BACKGROUND

Transgender services include treatment for gender dysphoria and gender incongruence. Treatment of gender dysphoria and gender incongruence is a Nevada Medicaid covered benefit, including both hormonal and surgical modalities, and psychotherapy, based on medical necessity. Genital reconstruction surgery (GRS) describes a number of surgical procedure options for the treatment of gender dysphoria and gender incongruence.

According to the World Professional Association for Transgender Health (WPATH), the organization that promotes the standards of health care for transsexual, transgender and gender nonconforming individuals, through the articulation of Standards of Care, gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at

birth (and the associated gender role and/or primary and secondary sex characteristics) and gender incongruence describes a marked and persistent experience of an incompatibility of gender identity and the gender expected based on birth-assigned sex.

COVERAGE RATIONALE

From the Medicaid Services Manual (MSM) Chapter 600 (Physician Services. Accessed 5/19/25, Current Effective Date 10/30/2024)

Genital Reconstruction Surgery –

- Genital reconstruction surgery is covered for recipients that are sufficiently physically fit and meet eligibility criteria under Nevada and federal laws.
- Prior authorization is required for all genital reconstruction surgery procedures.
- To qualify for surgery, the recipient must be 18 years of age or older.

Male-to-Female (MTF) recipient, surgical procedures may include:

a) breast/chest surgery; mammoplasty
b) genital surgery; orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy

Female-to-Male (FTM) recipient, surgical procedures may include:

a) breast/chest surgery; mastectomy
b) genital surgery; hysterectomy/salpingo-oophorectomy, phalloplasty, vaginectomy, vulvectomy, scrotoplasty

Augmentation mammoplasty for MTF recipients is a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy.

All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization. Refer to MSM Chapter 600, Section 603.4B for information regarding sterilization services.

Non-Covered Services – Payment will not be made for the following services and procedures:

a. Cryopreservation, storage and thawing of reproductive tissue, and all related services and costs;
b. Reversal of genital and/or breast surgery;
c. Reversal of surgery to revise secondary sex characteristics;
d. Reversal of any procedure resulting in sterilization;
e. Cosmetic surgery and procedures not deemed medically necessary.

Documentation Requirements (specific to surgery) –

The recipient must have:

a. Persistent and well-documented case of gender dysphoria and/or gender incongruence;

b. Capacity to make a fully informed decision and give consent for treatment. Informed consent refers to the process whereby the patient and the health care practitioner engage in a dialogue about a proposed medical treatment's nature, consequences, harms, benefits, risks and alternatives (ref: American Medical Association Journal of Ethics). Informed consent is a fundamental principle of health care.
c. Comprehensive mental health evaluation provided in accordance with WPATH standards of care; and
d. Prior to beginning stages of surgery, obtained authentic letters from two qualified licensed mental health professionals who have independently assessed the recipient and are referring the recipient for surgery. The two letters must be authenticated and signed by:
    1. A licensed qualified mental health care professional working within the scope of their license who have independently assessed the recipient;
        a) One with whom the recipient has an established ongoing relationship; and
        b) One who only has an evaluative role with the recipient.
    2. Together the letters must establish the recipient have:
        a) A persistent and well-documented case of gender dysphoria and/or gender incongruence;
        b) Received hormone therapy appropriate to the recipient's gender goals, which shall be for a minimum of 12 months in the case of a recipient seeking genital reconstruction surgery, unless such therapy is medically contraindicated or the recipient is otherwise unable to take hormones;
        c) Lived for 12 months in a gender role congruent with the recipient's gender identity without reversion to the original gender, and has received mental health counseling, as deemed medically necessary during that time; and
        d) Significant medical or mental health concerns reasonably well-controlled; and capacity to make a fully informed decision and consent to the treatment.
    3. When a recipient has previously had one or more initial surgical procedures outlined in this document, the recipient is not required to provide referral letters to continue additional surgical procedures, at the discretion of the surgeon. The surgeon must ensure this is clearly documented in the recipient's medical record.

Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization is required.

From the Medicaid Services Manual (MSM) Chapter 1200 (Prescribed Drugs. Accessed 5/19/25, Current Effective Date 5/5/2025)

Hormone Therapy –

Hormone Therapy is covered for treatment of gender dysphoria and gender incongruence based on medical necessity.

Topical Androgens, diagnosis of gender dysphoria

Approval will be given if the following criteria are met and documented:

a) recipient is using the hormones to change their physical characteristics; and
b) recipient is a female-to-male transsexual.

Xyosted™ (testosterone enanthate), diagnosis of gender dysphoria

Approval will be given if the following criteria are met and documented:

a) recipient is using the hormones to change their physical characteristics; and
b) recipient is a female-to-male transsexual.

Prior authorization approval with a diagnosis of gender dysphoria will be given for six months for recipients new to testosterone therapy; or

Prior authorization approval will be given to recipients continuing testosterone therapy without a current authorization on file for 12 months.

Oral Testosterone Products, diagnosis of gender dysphoria

Approval will be given if the following criteria are met and documented:

a) recipient is using the hormones to change their physical characteristics; and
b) recipient is a female-to-male transsexual.

Recipient must continue to meet criteria above; and

Recipient must have disease improvement and/or stabilization.

Prior authorization approval will be for 12 months.

GnRH Analogs (Lupron® [leuprolide]), diagnosis of gender dysphoria

Approval will be given if all the following criteria are met and documented.

a) Recipient must be under 18 years of age; and
b) The medication is being prescribed for suppression of puberty; and
c) The provider indicates a demonstrable knowledge what gonadotropins medically can and cannot do and their social benefits and risks; and
d) One of the following:
    a. A documented real-life experience (living as the other gender) for at least three months prior to the administration of gonadotropin; or
    b. A period of psychotherapy for a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months)
e) The member must meet the definition of gender dysphoria below:
    a. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
    b. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
    c. The disturbance is not concurrent with a physical intersex condition.
    d. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
    e. The transsexual identity has been present persistently for at least two years.
    f. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Mental Health Services –

Mental health services are covered for treatment of gender dysphoria and gender incongruence based on medical necessity; refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services for services and prior authorization requirements.

DEFINITIONS

Gender Dysphoria – the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics. (ref. Mayo Clinic.org, accessed 5/19/25).

Gender Incongruence – behavior that differs significantly from cultural norms for a person's birth sex (ref. Merck Manual, accessed 5/19/25)

Gender Identity or Expression - a gender-related identity, appearance, expression or behavior of a person, regardless of the person's assigned sex at birth.

Gender Reassignment – the act or process of changing from living as a person of one sex to living as a person of the opposite sex by undergoing surgery, hormone treatment, etc. to obtain the physical appearance of the opposite sex.

US FOOD AND DRUG ADMINISTRATION (FDA)

Gender reassignment surgeries are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics or tests used as a part of these procedures may be subject to FDA regulation. See the following website to search by product name. Available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed May 19, 2025)

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

CPT Code	Description
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
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less

CPT Code	Description
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
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 (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
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

CPT Code	Description
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 (e.g., 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
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
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)
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 (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)

CPT Code	Description
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
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
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

CPT Code	Description
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
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall;
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)
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)
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;

CPT Code	Description
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;
64856	Suture of major peripheral nerve, arm, or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm, or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
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

REFERENCES

Nevada Revised Statute (NRS) 424.0145 "Gender identity or expression" defined. (accessed 5/19/25)

Medicaid Services Manual (MSM) Chapter 600, pages 53-56 and Chapter 1200, pages 91-93 and 161-162. (accessed 5/19/25)

POLICY HISTORY/REVISION INFORMATION

Date	Name	Comments
3/17/23	Krystal Marshall	Initial Review by: HPN/SHL Utilization Management Committee
4/24/24	Arletta Bendschneider	Revision/Review *Non-Covered Services* section (e). Edited 'Cosmetic Surgery and procedures including:' to 'Cosmetic Surgery and procedures not deemed medically necessary.' *Documentation Requirements (specific to surgery)* section (a) and (d) 2a: Gender Dysphoria spelled out to 'Gender dysphoria and/or gender incongruence'. No longer noted as 'GD'.
6/4/25	Arletta Bendschneider	Revision/Review Gender Dysphoria now spelled out throughout

		the entire policy. No longer noted as 'GD'. Gender Incongruence added to all references of Gender Dysphoria, throughout the policy. Recertification and prior authorization guidelines added to the *Oral Testosterone Products* section under *Hormone Therapy*. Gender Incongruence defined in *Definitions* section. CPT code 15819 (Cervicoplasty) removed from *Applicable Codes* section (no longer an active ICD 10 code).