

**Policy:** 201609-CSTM

**Initial Effective Date:** 08/01/2016

**SUBJECT:** Gender Affirming Surgery

**Annual Review Date:** 03/23/2023

**Last Revised Date:** 06/29/2023

**Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.**

**Definition:** Gender dysphoria\* is the discomfort or distress that is caused by a discrepancy between an individual's gender identity and that individual's sex assigned at birth. Medical treatment of gender dysphoria includes hormone therapy and/or surgery, as well as psychotherapy including counseling and support. Gender affirming surgery refers to surgical procedures for the treatment of gender dysphoria. These types of surgeries may include several staged procedures.

Medical Mutual of Ohio respects gender diversity and has developed this corporate medical policy to assist our members who are diagnosed with gender dysphoria. This policy applies only to members diagnosed with gender dysphoria. Gender fluidity and other expressions of gender identity without a diagnosis of gender dysphoria are not covered by this policy.

**Medical Necessity:** The Company considers gender affirming surgery **medically necessary** and eligible for reimbursement providing that the following criteria are met:

For gender affirming chest surgery:

- A written assessment\* from at least one qualified behavioral health professional with competencies in the assessment of transgender and gender diverse people\*\* that documents that the individual meets **all** of the following:
  - ≥ 18 years old; and
  - Capacity to make a fully informed decision and consent for treatment that may be irreversible; and
  - Persistent, well-documented diagnosis of gender dysphoria\*\*\*; and
  - Absence of poorly controlled or unstable psychiatric condition; and
  - Gender incongruence is marked and sustained.

**NOTE:** Individuals under 18 years of age may be eligible for gender-affirming chest surgery providing that the above criteria are met (except for age) and the individual has completed at least 12 months of hormone therapy, unless medically contraindicated or hormone therapy is not desired.

For gender affirming genital surgery:

- A written assessment\* from at least one qualified behavioral health professional\*\* with competencies in the assessment of transgender and gender diverse people that documents that the individual meets **all** of the following:
  - ≥ 18 years old; and
  - Capacity to make a fully informed decision and consent for treatment that may impact reproduction and may be irreversible; and
  - Persistent, well-documented diagnosis of gender dysphoria\*\*\*; and
  - Absence of poorly controlled or unstable psychiatric condition; and
  - Stable hormone therapy treatment regimen of at least 6 continuous months unless medically contraindicated or hormone treatment is not desired; and

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- Gender incongruence is marked and sustained.

**Medically necessary** surgical procedures may include the following:

- Breast augmentation, clitoroplasty, coloproctostomy, labiaplasty, orchiectomy, penectomy, vaginoplasty, urethroplasty, vulvoplasty, bilateral mastectomy or breast reduction, hysterectomy, implantation of penile and/or testicular prostheses, metoidioplasty, nipple-areola reconstruction following gender-affirming mastectomy<sup>†</sup>, salpingo-oophorectomy, urethroplasty, phalloplasty, scrotoplasty, vaginectomy, vulvectomy.

<sup>†</sup>**NOTE:** CPT code 19318 (breast reduction) includes the work necessary to reposition and reshape the nipple and areola. CPT code 19350 (nipple/areola reconstruction) is considered integral to CPT code 19318; thus CPT codes 19350 and 19318 should not be billed together for mastectomy for the purpose of gender affirming surgery. However, when appropriate, CPT code 19350 may be requested along with CPT code 19303 (mastectomy, simple, complete).

The Company considers certain procedures that may be related to gender affirming surgery to be **cosmetic** and **not** eligible for reimbursement, including but not limited to the following:

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|--|---|
| • Abdominoplasty   | • Lipofilling   |
| • Blepharoplasty <sup>††</sup>   | • Liposuction or lipoplasty   |
| • Botulinum toxin  | • Lip reduction/enhancement <sup>††</sup>                             |
| • Brow lift <sup>††</sup>  | • Neck tightening   |
| • Calf implants  | • Pectoral implants   |
| • Collagen injections  | • Removal of redundant skin   |
| • Dermal filler injections   | • Rhinoplasty <sup>††</sup>   |
| • Facial implants  | • Skin resurfacing  |
| • Gluteal augmentation including implants/lipofilling                                    | • Thyroid chondroplasty (reduction of the Adam's apple) <sup>††</sup> |
| • Hair reconstruction including permanent hair removal <sup>†††</sup> or hair transplant | • Other aesthetic or cosmetic procedures not listed                   |
| • Laryngoplasty  |   |

<sup>††</sup>**NOTE:** Facial modifications, including facial feminization and facial masculinization procedures, are considered **medically necessary** and eligible for reimbursement for the treatment of gender dysphoria, provided that the member meets criteria listed above for gender-affirming genital surgery.

**These exclusions are subject to change based on any updated recommendations set forth by WPATH.**

Please note that while the above procedures may not be covered under this Corporate Medical Policy, members may be eligible when certain criteria are met. Please consult our library of Corporate Medical Policies as well as the MCG provider transparency portal for further details.

<sup>†††</sup>**NOTE:** Laser or electrolysis hair removal (**CPT Code 17380**) to treat tissue donor sites for a planned genital surgery, when prescribed by a physician for treatment for gender dysphoria, is considered **medically necessary** and eligible for reimbursement.

The Company considers certain procedures as **not medically necessary** and **not** eligible for reimbursement when performed as part of gender affirming surgery, including but not limited to the following:

- Speech therapy for vocal training.

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- Vocal cord procedures (voice modification surgery).
- Gender affirming surgeries for diagnoses other than gender dysphoria.

**OTHER IMPORTANT NOTES:**

- Reversal of gender affirming surgery is considered **medically necessary** and eligible for reimbursement providing that the medical necessity criteria above are met.
- Coverage for fertility preservation services (cryopreservation, storage and thawing of reproductive tissue) is subject to limitations or exclusions in the individual's health benefit plan. Please consult plan documents for more information.
- Certain gender-specific services may be considered **medically necessary** for transgender persons appropriate to their anatomy. Examples include:
  - Breast cancer screening for transmasculine persons who have not undergone chest masculinization surgery;
  - Prostate cancer screening for transfeminine persons who have retained their prostate.
- Hormone therapy is subject to the individual's prescription drug benefit plan.
- Current certificate books exclude coverage for surgical and non-surgical management of gender dysphoria. To verify coverage, refer to member mailings and updated certificate books as they become available.

**\*Written documentation includes a letter of referral and should cover six key elements:**

1. The patient's general identifying characteristics.
2. Results of the patient's psychosocial assessment including any diagnoses.
3. Duration of the mental health professional's relationship with the patient including the type and duration of counseling or therapy to date.
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale supporting the patient's request for surgery.
5. A statement confirming that informed consent has been obtained from the patient.
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this relationship.

**\*\*World Professional Association for Transgender Health Standards of Care version 8 (2022)** recommends the following characteristics of a qualified health professional:

1. Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
2. Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
3. Are able to assess capacity to consent for treatment.
4. Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
5. Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.
6. Liaise with professionals from different disciplines within the field of transgender health for consultation and referral on behalf of gender diverse adults seeking gender-affirming treatment, if required.

World Professional Association for Transgender Health Standards of Care version 8 (2022) recommends that a qualified surgeon has the following credentials:

1. Training and documented supervision in gender-affirming procedures;
2. Maintenance of an active practice in gender-affirming surgical procedures;
3. Knowledge about gender diverse identities and expressions;

4. Continuing education in the field of gender-affirmation surgery;
5. Tracking of surgical outcomes.

\*\*\***Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Criteria for Gender Dysphoria (APA, 2013):**

**Gender dysphoria in Adolescents and Adults**

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:
  1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
  4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**With a disorder of sex development** (e.g., a congenital adrenogenital disorder such as 2.55.2 [E25.0] congenital adrenal hyperplasia or 259.0 [E34.50] androgen insensitivity syndrome).

**Coding note:** Code the disorder of sex development as well as gender dysphoria.

*Specify if:*

**Post transition:** The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen- namely regular cross-sex treatment or gender affirming surgery confirming the desired gender (e.g., appendectomy, vaginoplasty in the natal male; mastectomy or phalloplasty in the natal female).

*Medical Mutual of Ohio complies with the Mental Health Parity and Addiction Equality Act (MHPAE). This Corporate Medical Policy applies to covered plans (individual and group) which are subject to the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) and to groups who may be exempt from the requirements of MHPAEA but still elect to provide coverage.*

**Documentation Requirements:**

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary,

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investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

**NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.**

***Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.***

*Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.*

## Sources of Information:

- American College of Obstetricians and Gynecologists (ACOG). (2021, March). Health Care for Transgender and Gender Diverse Individuals (Number 823). Retrieved from <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>. Accessed January 31, 2023.
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.
- Endocrine Society, Pediatric Endocrine Society. (2020). Transgender Health: An Endocrine Society Position Statement. Available at: <https://www.endocrine.org/advocacy/position-statements/transgender-health>. Accessed February 1, 2023.
- Hayes, Inc. Sex Reassignment Surgery for the Treatment of Gender Dysphoria. (2018, August 1). Annual review July 27, 2022. Houston, TX.
- Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, ... T'Sjoen GG. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*, 102(11):3869–3903.
- Loree JT, Burke MS, Rippe B, Clarke S, Moore SH, Loree TR. (2020). Transfeminine Gender Confirmation Surgery with Penile Inversion Vaginoplasty: An Initial Experience. *Plast Reconstr Surg Glob Open*, 8(5):e2873.
- Schönauer LM, Dellino M, Loverro M, Carriero C, Capursi T, Leoni C, ... Di Naro E. (2020). Hormone therapy in female-to-male transgender patients: searching for a lifelong balance. *Hormones (Athens)*, 20(1):151-159.
- UpToDate, Waltham, MA:
  - Ferrando C, Zhao LC, Nikolavsky D. (2022). Gender-affirming surgery: Female to male. Brubaker L (Ed).
  - Ferrando C, Thomas TN. (2022). Gender-affirming surgery: Male to female. Brubaker L (Ed).
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- van de Grift TC, Kreukels BPC, Elfering L, Özer M, Bouman M-B, Buncamper ME, ... Mullender MG. (2016). Body Image in Transmen: Multidimensional Measurement and the Effects of Mastectomy. *J Sex Med*, 13(11):1778–1786.
- World Professional Association for Transgender Health (WPATH). (2022). Standards of Care for the Health of Transgender and Gender Diverse People. Version 8. Minneapolis, MN: World Professional Association for Transgender Health (WPATH). Available at: <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>. Accessed January 31, 2023.

<b>Applicable Code(s):</b>	
<b>CPT:</b>	17380, 17999, 19303, 19318, 19325, 19340, 19342, 19350, 44145, 53430, 54125, 54400, 54401, 54405, 54520, 54660, 54690, 55180, 55970, 55980, 56625, 56800, 56805, 57110, 57291, 57292, 57335, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661
<b>HCPCS:</b>	L8699
<b>ICD-10-CM Procedure Codes</b>	0UQG0ZZ, 0UQJ0ZZ-0UQJXZZ, 0UT20ZZ-0UT2FZZ, 0UT70ZZ-0UT7FZ, 0UT90ZZ-0UT9FZZ, 0UTC0ZZ-0UTC8ZZ, 0UTG0ZZ-0UTG8ZZ, 0UTJ0ZZ-0UTJXZZ, 0UTM0ZZ-0UTMXZZ, 0VRC0JZ, 0VTC0ZZ-0VTC4ZZ, 0VTS0ZZ-0VTSXZZ, 0VUS07Z-0VUSX7Z, 0VUS0JZ-0VUSXJZ, 0VUS0KZ-0VUSXKZ, 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1
<b>ICD10 Diagnosis Codes:</b>	F64.0, F64.1, F64.2, F64.8, F64.9

**Revised:**

- 08/01/2016: Policy created.
- 12/13/2017: Medical necessity, Sources of Information and Edits and Denials sections updated.
- 03/16/2018: Added F64.0 to the list of valid ICD-10 diagnosis codes.
- 11/05/2019: Updated date of annual review.
- 11/16/2020: Title changed to *Gender Reassignment Surgery*. CPT 19304 removed from policy. Sources of information updated.
- 08/10/2021: Title changed to *Gender Affirming Surgery*. Edits and denials updated. Specific duration requirement removed for history of gender dysphoria diagnosis.
- 10/06/2021: *Gender reassignment* terminology replaced throughout with *gender affirming* terminology. Nipple reconstruction (CPT code 19350) added to policy as covered for FtM surgery. Added CPT Code 17999 and HCPCS Code L8699 to pend for prior approval. 19318 added to policy. Clarification added regarding mastectomy/reduction mammoplasty codes. Breast augmentation (CPT Codes 19325, 19340, 19342) added to policy as covered for MtF surgery. Sources of Information updated.
- 01/11/2022: Coloproctostomy added to policy (CPT code 44145).
- 02/11/2022: Compliance with Mental Health Parity and Addiction Equality Act (MHPAE) statement added.
- 07/06/2022: Laser/electrolysis hair removal (CPT Code 17380) for donor sites was added to policy as medically necessary.
- 03/23/2022: Sources of information updated. Criteria updated to reflect the release of World Professional Association for Transgender Health Standards of Care Version 8.

## Edits and Denials

**Prior approval:** Prior approval is required for gender reassignment surgery (CPT Codes 19303, 19318, 19325, 19340, 19342, 19350, 57335, HCPCS Code L8699, and ICD-10-CM Procedure Codes 0UQG0ZZ, 0UQJ0ZZ-0UQJXZZ, 0UT20ZZ-0UT2FZZ, 0UT70ZZ-0UT7FZ, 0UT90ZZ-0UT9FZZ, 0UTC0ZZ-0UTC8ZZ, 0UTG0ZZ-0UTG8ZZ, 0UTJ0ZZ-0UTJXZZ, 0UTM0ZZ-0UTMXZZ, 0VRC0JZ, 0VTC0ZZ-0VTC4ZZ, 0VTS0ZZ-0VTSXZZ, 0VUS07Z-0VUSX7Z, 0VUS0JZ-0VUSXJZ, 0VUS0KZ-0VUSXKZ, 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1). Requests for prior approval will be authorized by a nurse reviewer if submitted documentation meets criteria outlined within the Corporate Medical Policy.

Requests for prior approval for gender reassignment surgery will be forwarded to a qualified physician reviewer if submitted documentation does not meet criteria outlined within the Corporate Medical Policy.

**TOPPS:** Claims received with surgery (CPT Codes 19303, 57335, and HCPCS Code L8699) will pend to Care Authorizations with **Remark Code M6D**. If prior approval is on file, the claim will be processed according to the determination decision. If prior approval is not on file, the claim will be denied due to insufficient information to establish medical necessity with **Remark Code MNP**. Claims received with **CPT Codes 19318, 19325, 19340, 19342, or 19350** may pend to Care Authorizations with **Remark Code COS** for review as potentially cosmetic.

**Institutional:** Claims received with ICD-10-CM Procedure Codes 0UQG0ZZ, 0UQJ0ZZ-0UQJXZZ, 0UT20ZZ-0UT2FZZ, 0UT70ZZ-0UT7FZ, 0UT90ZZ-0UT9FZZ, 0UTC0ZZ-0UTC8ZZ, 0UTG0ZZ-0UTG8ZZ, 0UTJ0ZZ-0UTJXZZ, 0UTM0ZZ-0UTMXZZ, 0VRC0JZ, 0VTC0ZZ-0VTC4ZZ, 0VTS0ZZ-0VTSXZZ, 0VUS07Z-0VUSX7Z, 0VUS0JZ-0VUSXJZ, 0VUS0KZ-0VUSXKZ, 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1 will pend to Care Authorizations with **Remark Code ZMQ**. If prior approval is on file, the claim will be processed according to the determination decision. If prior approval is not on file, the claim will be denied due to insufficient information to establish medical necessity with **Remark Code MNP**.

**Liability:** A participating provider will be required to write off charges denied as not medically necessary.



<b>CPT Code(s):</b>	
17380	Electrolysis epilation, each 1/2 hour
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
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
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis
54690	Laparoscopy, surgical; orchiectomy
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;
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);
58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
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)

<b>HCPCS Code(s):</b>	
L8699	Prosthetic implant, not otherwise specified

**ICD-10-CM Procedure Code(s):**

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0UQG0ZZ	Repair vagina, open approach
0UQJ0ZZ- 0UQJXZZ	Repair clitoris [by approach; includes codes 0UQJ0ZZ, 0UQJXZZ]
0UT20ZZ- 0UT2FZZ	Resection of bilateral ovaries [by approach; includes codes 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ]
0UT70ZZ- 0UT7FZZ	Resection of bilateral fallopian tubes [by approach; includes codes 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ]
0UT90ZZ- 0UT9FZZ	Resection of uterus [by approach; includes codes 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ]
0UTC0ZZ- 0UTC8ZZ	Resection of cervix [by approach; includes codes 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ]
0UTG0ZZ- 0UTG8ZZ	Resection of vagina [by approach; includes codes 0UTG0ZZ, 0UTG4ZZ, 0UTG7ZZ, 0UTG8ZZ]
0UTJ0ZZ- 0UTJXZZ	Resection of clitoris [by approach; includes codes 0UTJ0ZZ, 0UTJXZZ]
0UTM0ZZ- 0UTMXZZ	Resection of vulva [by approach; includes codes 0UTM0ZZ, 0UTMXZZ]
0VRC0JZ	Replacement of bilateral testes with synthetic substitute, open approach
0VTC0ZZ- 0VTC4ZZ	Resection of bilateral testes [by approach; includes codes 0VTC0ZZ, 0VTC4ZZ]
0VTS0ZZ- 0VTSXZZ	Resection of penis [by approach; includes codes 0VTS0ZZ, 0VTS4ZZ, 0VTSXZZ]
0VUS07Z- 0VUSX7Z	Supplement penis with autologous tissue substitute [by approach, includes codes 0VUS07Z, 0VUS47Z, 0VUSX7Z]
0VUS0JZ- 0VUSXJZ	Supplement penis with synthetic substitute [by approach; includes codes 0VUS0JZ, 0VUS4JZ, 0VUSXJZ]
0VUS0KZ- 0VUSXKZ	Supplement penis with nonautologous tissue substitute [by approach; includes codes 0VUS0KZ, 0VUS4KZ, 0VUSXKZ]
0W4M070	Creation of vagina in male perineum with autologous tissue substitute, open approach
0W4M0J0	Creation of vagina in male perineum with synthetic substitute, open approach
0W4M0K0	Creation of vagina in male perineum with nonautologous tissue substitute, open approach
0W4M0Z0	Creation of vagina in male perineum, open approach
0W4N071	Creation of penis in female perineum with autologous tissue substitute, open approach
0W4N0J1	Creation of penis in female perineum with synthetic substitute, open approach
0W4N0K1	Creation of penis in female perineum with nonautologous tissue substitute, open approach
0W4N0Z1	Creation of penis in female perineum, open approach

**ICD-10-CM Diagnosis Code(s):**

F64.0	Transsexualism
F64.1	Gender identity disorders in adolescence and adulthood
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorder
F64.9	Gender identity disorder, unspecified