Gender Dysphoria and Gender Reassignment Surgery

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➲ Instructions for Use

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Coverage Rationale

Overview

Gender reassignment surgery is a general term to describe a surgery or surgeries that affirm a person's gender identity.

CMS National Coverage Determinations (NCDs)

NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery states, the Centers for Medicare & Medicaid Services (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery. 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.

CMS Local Coverage Determinations (LCDs) and Articles

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Gender Dysphoria and Gender Reassignment Surgery.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Gender Dysphoria Treatment.

Note: Cross sex hormone therapy may be covered as part of gender dysphoria treatment; Part B vs Part D coverage rules also apply. For Part B vs Part D medication coverage guidelines, refer to the Coverage Summary titled Medications/Drugs (Outpatient/Part B).

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; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document 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
Male to Female	
19325	Breast augmentation with implant
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55970	Intersex surgery; male to female
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
Female to Male	
19303	Mastectomy, simple, complete
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
57106	Vaginectomy, partial removal of vaginal wall
57110	Vaginectomy, complete removal of vaginal wall
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

CPT Code	Description
Female to Male	
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
Other Ancillary Services	
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
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 (e.g., 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 (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

CPT Code	Description
Other Ancillary Services	
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper lid; 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 (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
19316	Mastopexy
19318	Breast reduction
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

CPT Code	Description
Other Ancillary Services	
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)
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
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
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
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

CPT Code	Description
Other Ancillary Services	
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, two or more individuals

Diagnosis Code	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

ICD Procedure Code	Description
0U5J0ZZ	Destruction of clitoris, open approach
0U5JXZZ	Destruction of clitoris, external approach
0UB24ZZ	Excision of bilateral ovaries, percutaneous endoscopic approach
0UB74ZZ	Excision of bilateral fallopian tubes, percutaneous endoscopic approach
0UBJ0ZZ	Excision of clitoris, open approach
0UBJXZZ	Excision of clitoris, external approach
0UCJ0ZZ	Extirpation of matter from clitoris, open approach
0UCJXZZ	Extirpation of matter from clitoris, external approach
0UNJ0ZZ	Release clitoris, open approach
0UNJXZZ	Release clitoris, external approach
0UQG0ZZ	Repair vagina, open approach
0UQJ0ZZ	Repair clitoris, open approach
0UT20ZZ	Resection of bilateral ovaries, open approach
0UT24ZZ	Resection of bilateral ovaries, percutaneous endoscopic approach
0UT27ZZ	Resection of bilateral ovaries, via natural or artificial opening
0UT28ZZ	Resection of bilateral ovaries, via natural or artificial opening endoscopic
0UT2FZZ	Resection of bilateral ovaries, via natural or artificial opening with percutaneous endoscopic assistance
0UT70ZZ	Resection of bilateral fallopian tubes, open approach
0UT74ZZ	Resection of bilateral fallopian tubes, percutaneous endoscopic approach
0UT77ZZ	Resection of bilateral fallopian tubes, via natural or artificial opening
0UT78ZZ	Resection of bilateral fallopian tubes, via natural or artificial opening endoscopic
0UT7FZZ	Resection of bilateral fallopian tubes, via natural or artificial opening with percutaneous endoscopic assistance
0UT90ZZ	Resection of uterus, open approach
0UT94ZZ	Resection of uterus, percutaneous endoscopic approach
0UT97ZZ	Resection of uterus, via natural or artificial opening
0UT98ZZ	Resection of uterus, via natural or artificial opening endoscopic

ICD Procedure Code	Description
0UT9FZZ	Resection of uterus, via natural or artificial opening with percutaneous endoscopic assistance
0UTC0ZZ	Resection of cervix, open approach
0UTC4ZZ	Resection of cervix, percutaneous endoscopic approach
0UTC7ZZ	Resection of cervix, via natural or artificial opening
0UTC8ZZ	Resection of cervix, via natural or artificial opening endoscopic
0UTG0ZZ	Resection of vagina, open approach
0UTG4ZZ	Resection of vagina, percutaneous endoscopic approach
0UTG7ZZ	Resection of vagina, via natural or artificial opening
0UTG8ZZ	Resection of vagina, via natural or artificial opening endoscopic
0UTJ0ZZ	Resection of clitoris, open approach
0UTJXZZ	Resection of clitoris, external approach
0UTM0ZZ	Resection of vulva, open approach
0UTMXZZ	Resection of vulva, external approach
0UUJ07Z	Supplement clitoris with autologous tissue substitute, open approach
0UUJ0JZ	Supplement clitoris with synthetic substitute, open approach
0UUJ0KZ	Supplement clitoris with nonautologous tissue substitute, open approach
0UUJX7Z	Supplement clitoris with autologous tissue substitute, external approach
0UUJXJZ	Supplement clitoris with synthetic substitute, external approach
0UUJXKZ	Supplement clitoris with nonautologous tissue substitute, external approach
0VRC0JZ	Replacement of bilateral testes with synthetic substitute, open approach
0VTC0ZZ	Resection of bilateral testes, open approach
0VTC4ZZ	Resection of bilateral testes, percutaneous endoscopic approach
0VTS0ZZ	Resection of penis, open approach
0VTS4ZZ	Resection of penis, percutaneous endoscopic approach
0VTSXZZ	Resection of penis, external approach
0VUS07Z	Supplement penis with autologous tissue substitute, open approach
0VUS0JZ	Supplement penis with synthetic substitute, open approach
0VUS0KZ	Supplement penis with nonautologous tissue substitute, open approach
0VUS47Z	Supplement penis with autologous tissue substitute, percutaneous endoscopic approach
0VUS4JZ	Supplement penis with synthetic substitute, percutaneous endoscopic approach
0VUS4KZ	Supplement penis with nonautologous tissue substitute, percutaneous endoscopic approach
0VUSX7Z	Supplement penis with autologous tissue substitute, external approach
0VUSXJZ	Supplement penis with synthetic substitute, external approach
0VUSXKZ	Supplement penis with nonautologous tissue substitute, external approach
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
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

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Gender Dysphoria and Gender Reassignment Surgery				
NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery	N/A	A53793 Billing and Coding: Gender Reassignment Services for Gender Dysphoria	Part A and B MAC	Palmetto**

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

CMS Benefit Policy Manual

Chapter 16; § 120 Cosmetic Surgery, § 180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

CMS Transmittal(s)

Transmittal 194, Change Request 9981, Dated 03/03/2017 (Gender Dysphoria and Gender Reassignment Surgery)

CMS Claims Processing Manual

Chapter 1, § 60.1 General Information on Noncovered Charges

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Many gender reassignment interventions are surgical procedures and are not subject to FDA approval. However, devices and instruments used during the procedures may require FDA approval. Refer to the following website for additional information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm . (Accessed June 25, 2024)

Policy History/Revision Information

Date	Summary of Changes
10/01/2024	**Centers for Medicare & Medicaid (CMS) Related Documents** • Added notation for the state of Virginia to indicate “Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction”
09/01/2024	**Title Change/Template Update** • Previously titled *Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)* • Reformatted and reorganized policy; transferred content to new template

Date	Summary of Changes

	• Changed policy type classification from “Policy Guideline” to “Medical Policy”
	• Added *FDA* section
	• Updated *Instructions for Use*
	Related Policies
	• Added reference link to the:
	  ○ UnitedHealthcare Medicare Advantage Coverage Summary titled *Medications/Drugs (Outpatient/Part B)*
	  ○ UnitedHealthcare Medicare Advantage Medical Policy titled *Ear, Nose, and Throat Procedures*
	• Removed reference link to the UnitedHealthcare Medicare Advantage Reimbursement Policy titled *Global Days Policy, Professional*
	Coverage Rationale
	CMS Local Coverage Determinations (LCDs) and Articles
	• Added language to indicate:
	  ○ Cross sex hormone therapy may be covered as part of gender dysphoria treatment; Part B vs Part D coverage rules also apply
	  ○ For Part B vs Part D medication coverage guidelines, refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Medications/Drugs (Outpatient/Part B)*
	Applicable Codes
	• Removed CPT codes 19340 and 19342
	• Removed instruction to refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
	  ○ *Cosmetic and Reconstructive Services and Procedures* for CPT codes 11950, 11951, 11952, 11954, 14000, 14001, 14041, 15734, 15738, 15769, 15771, 15772, 15773, 15774, 15775, 15776, 15780, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 15819, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17380, 19316, 19318, 19325, 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21208, 21209, 21270, 30400, 30410, 30420, 30430, 30435, and 30450
	  ○ *Blepharoplasty, Blepharoptosis, and Brow Lift* for CPT codes 15820, 15821, 15822, 15823, and 67900
	Centers for Medicare and Medicaid Services (CMS) Related Documents
	• Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information
	• Added list of applicable *Medicare Administrative Contractors (MACs) With Corresponding States/Territories*
	• Added notation to indicate the Wisconsin Physicians Service Insurance Company (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
	• Removed reference link to the Centers for Medicare & Medicaid (CMS) *Transmittal 169, Change Request 8825, Dated 06/27/2014 (Invalidation of National Coverage Determination 140.3 – Transsexual Surgery)*
	Supporting Information
	• Archived previous policy version MPG365.09

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their

independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.