
APPLYING AND UNDERSTANDING
THE WPATH STANDARDS OF CARE (SOC)
THROUGH THE HEALTHCARE PROVIDERS LENS
WELCOME
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WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

Primary Care

Insurance Coverage and Coding Considerations in Gender Affirming Primary Care

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Outline

- Health disparities specific to the primary care context
- General primary care and coding
- Hormone therapy & reproductive health considerations and coding
- Common pitfalls and challenges
- Costing considerations

- Additional context of state and local regulations, requirements, and exclusions

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Table 2.

Ann Fam Med. 2020 Nov; 18(6): 528–534.

Association Between Insurance Status and Gender-Affirming Hormone Use Among Respondents the 2015 US Transgender Survey

Characteristic	Use of Nonprescription Hormones, Among Those Using Hormones[a] (n = 12,037)		Use of Hormones, Among Those Interested (n = 21,237)	
	aOR (95% CI)	*P* Value	aOR (95% CI)	*P* Value
Uninsured (compared with insured)	2.64 (1.88-3.71)	<.001	0.37 (0.24-0.56)	<.001

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Table 3.

Ann Fam Med. 2020 Nov; 18(6): 528–534.

Association Between Insurance Claim Denial and Gender-Affirming Hormone Use Among Insure Respondents to the 2015 US Transgender Survey

Characteristic	Use of Nonprescription Hormones, Among Those Using Hormones[a] (n = 10,841)		Use of Hormones, Among Those Interested (n = 18,516)	
	aOR (95% CI)	*P* Value	aOR (95% CI)	*P* Value
Claim for hormones denied by insurance	2.53 (1.61-3.97)	<.001	0.89 (0.57-1.39)	.60

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"Gender-specific" screenings

- Cervical cancer
- Breast cancer
- Bone density testing

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Can Fam Physician. 2019 Jan; 65(1): e30–e37.

Table 4.

Unadjusted and adjusted ORs comparing likelihood of trans individuals being screened for cancer compared with cis individuals

TYPE OF CANCER SCREENING	UNADJUSTED OR (95% CI)	ADJUSTED OR* (95% CI)
Cervical	0.46 (0.30 to 0.72)	0.39 (0.25 to 0.62)
Breast	0.28 (0.13 to 0.60)	0.27 (0.12 to 0.59)
Colorectal	0.51 (0.27 to 0.99)	0.50 (0.26 to 0.99)

OR—odds ratio.

*Adjusted for age, neighbourhood income quintile, and number of visits.

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	Transgender female	Transgender male without top surgery	Transgender male who has undergone top surgery
University of California San Francisco29	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography every 2 years	Screening similar to that for cisgender women	Dialog with patients about risks
Fenway Health30	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography annually	Screening similar to that for cisgender women	Consider yearly chest examinations
University Hospitals Cleveland Medical Center31	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography every 2 years	Screening similar to that for cisgender women	–
Susan G. Komen Puget Sound32	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography annually	Annual screening mammography beginning at age 50 years	Annual chest and axillary examinations If breast tissue remaining, annual screening mammography beginning at age 50 years
Canadian Cancer Society33	Age 50–69 years AND at least 5 years of hormone therapy: screening mammography every 2 years	Screening mammography every 2 years between age 50 and 69 years	Screening mammography every 2 years between age 50 and 69 years
Endocrine Society Clinical Practice Guidelines34	Screening similar to that for cisgender women, no prescribed length of hormone exposure	Screening similar to that for cisgender women	–

Breast Oncology | Published: 07 June 2021

Breast Cancer Risk and Screening in Transgender Persons: A Call for Inclusive Care

Callista N. Clarke MD, MS, FACS, FSSO, Chandler S. Cortina MD, Oluwadamilola M. Fayanju MD, MA, MPHS, Lesly A. Dossett MD, MPH, Fabian M. Johnston MD, MHS & Sandra L. Wong MD, MS

Annals of Surgical Oncology (2021) | Cite this article

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Cervical screening pitfalls

- Denial of coverage
- Inability to enter order
- Mismatch
- Changed to anal screening order

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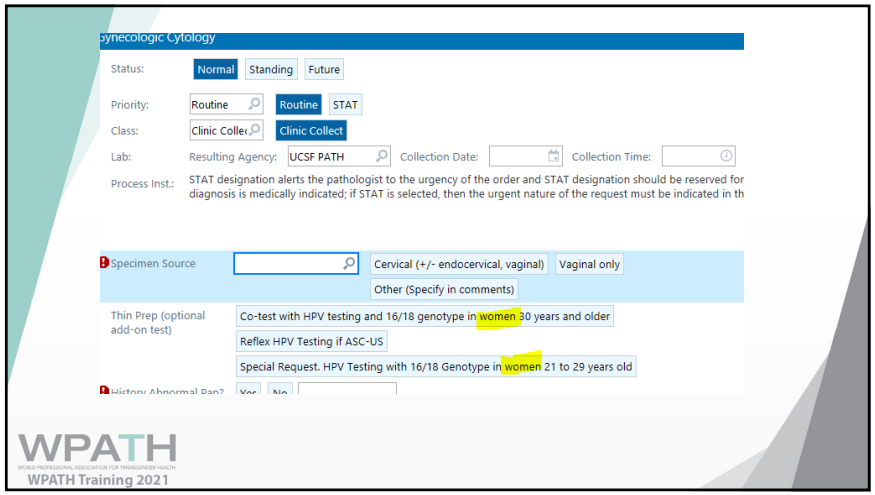

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"Gender-specific diagnostics and treatment"

- Testicular
- Penile
- Vaginal
- Vulvar
- Uterine
- Ovarian
- Breast
- Cervical

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"Gender-specific" diagnostics and treatment

- Will conflicts, no-match, or denials arise when facing these scenarios?

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575960	Gender dysphoria	F64.9
593625	Gender dysphoria in adolescent and adult	F64.0
1547864	Gender dysphoria in adult	F64.0
593626	Gender dysphoria in pediatric patient	F64.2
196359	Gender identity disorder	F64.9
441303	Gender identity disorder in adolescence and adulthood	F64.0
302.85.ICD-9	Gender identity disorder in adolescents or adults	F64.0
425524	Gender identity disorder in adult	F64.0
302.6.ICD-9-(	Gender identity disorder in children	F64.2
1547460	Gender identity disorder in pediatric patient	F64.2
176246	Gender identity disorder of adolescence	F64.0
176247	Gender identity disorder of adolescence, previously asexual	F64.0
176249	Gender identity disorder of adolescence, previously heterosexual	F64.0

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453054	Family history of gender identity disorder	Z81.8
514848	H/O gender identity disorder	Z86.59
1735909	History of gender dysphoria in childhood	Z86.59
452195	History of gender identity disorder	Z86.59
514849	Hx of gender identity disorder	Z86.59
1482472	Other gender identity disorders	F64.8
325110	Person who has undergone gender reassignment surgery	Z87.890
296186	Sexual and gender identity disorders	F64.2
1750529	Sexual relationship problem due to gender identity confusion	F66
325109	Status post gender reassignment surgery	Z87.890
325144	Trans-sexualism, status post gender reassignment surgery	Z87.890

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Other encounter diagnostic codes

1312060	Hypogonadism in male	E29.1
260254	Hypogonadism male	E29.1
260255	Hypogonadism with anosmia (CMS code)	E23.0
213426	Hypogonadism, hypogonadotropic, with anosmia (CMS code)	E23.0
260256	Hypogonadism, male	E29.1
1609202	Hypogonadism, mitral valve prolapse, and intellectual disability syndrome	Q87.89, E29.1, I34.1,
289700	Hypogonadism, ovarian	E28.39
260257	Hypogonadism, testicular	E29.1
178667	Endocrine disorder related to puberty	E34.8
1431555	Endocrine disorder, unspecified	E34.9

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Reproductive health and fertility considerations

- Pre-treatment preservation (sperm, oocyte, embryo, gonadal tissue)
- Post-treatment gamete production and conception
- Contraception prescribing
- Contraception procedures (implant, IUD)
- Sterilization procedures NOT relating to gender affirmation
  - Vasectomy/Tubal ligation

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516879	Infertility due to luteal phase defect	N97.8
174465	Infertility due to obstruction of efferent ducts	N46.8
517804	Infertility due to oligo-ovulation	N97.0
174456	Infertility due to oligospermia	N46.11
223170	Infertility due to spermatogenic arrest (complete)	N46.01
244434	Infertility male	N46.9
248835	Infertility management	Z31.9
454786	Infertility of tubal origin	N97.1
223290	Infertility with anomaly of cervical mucus	N88.3
223292	Infertility with dysmucorrhea	N88.3
439846	Infertility, anovulation	N97.0
226954	Infertility, female	N97.9
378649	Infertility, female, due to immunological factor	N97.8
260681	Infertility, female, origin, cervical	N88.3
260682	Infertility, female, origin, vaginal	N97.8

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Medical vs. pharmacy plan conflicts

- Injected medications (testosterone, estradiol, leuprolide) may be listed covered under medical plan
- Requirement for in-office injections may be prohibitive
- Lack of pre-approval or pre-authorization may put patient at risk of uncovered costs not discovered until after treatment received

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Cracking the Code to Better Health

Medical 'Z-codes' tied to social issues like homelessness and unemployment offer data that can help improve patients' lives and, in turn, their health. Why aren't more physicians using them?

By Sarah True | Jan. 13, 2021, at 6:30 a.m.

U.S.News & World Report

Ultimately, a lack of insurance reimbursement may explain why these Z-codes are so little used. Insurance companies pay for services based on diagnosis and procedure codes contained in medical documentation and submitted in claims, but Z-codes for social determinants of health don't trigger such payments, and this means "there's not a reason for providers to use them," Donovan says.

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AMA AMERICAN MEDICAL ASSOCIATION

CPT® Evaluation and Management (E/M)

Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes

This document includes the following CPT E/M changes,

effective January 1, 2021:

- **E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215**
- **Revised Office or Other Outpatient E/M codes 99202-99215**

In addition, this document has been updated to reflect technical corrections to the E/M Guidelines:

were posted on March 9, 2021 and effective January 1, 2021:

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

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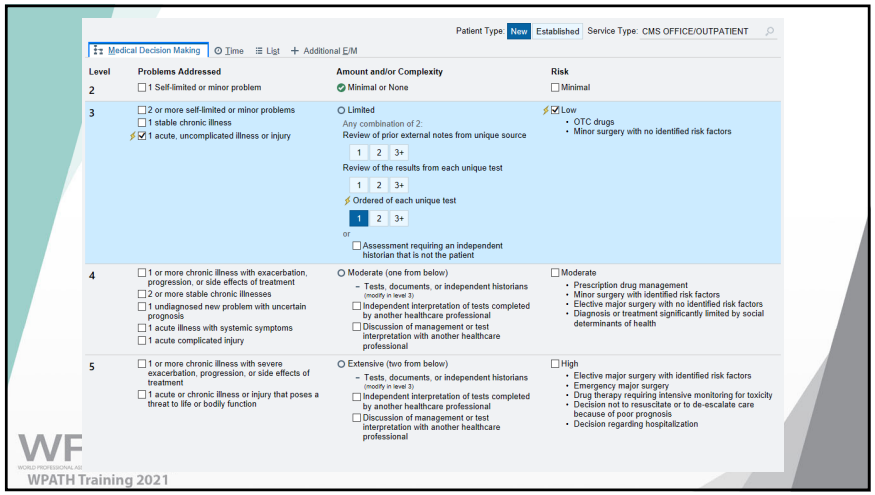

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Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) for other office or other outpatient services are:

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, noninsulin- dependent diabetes, cataract, or benign prostatic hyperplasia.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

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J Gen Intern Med. 2016 Apr; 31(4): 394–401. PMCID: PMC4803686
Published online 2015 Oct 19. doi: 10.1007/s11606-015-3529-6 PMID: 26481647

Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis

William V. Padula, PhD MS MSc,[1] Shiona Heru, JD,[2] and Jonathan D. Campbell, PhD[3]

- Roughly $10,000/QALY at 10 years cost
  - $100,000/QALY is the Willingness-to-pay threshold
- Cost of $0.016 PMPM for coverage of entire US trans population

Table 4 Expected results of the base case cost-effectiveness analysis

	Cost (USD 2013)	Δ Cost	Health Utility (QALYs)	Δ Utility	ICER ($/QALY)
5-Year Time Horizon					
No Health Benefit	10,712.00		3.71		
Provider Coverage	21,326.00	10,614.00	3.98	0.27	39,311.11
Male-to-Female (MTF)*	22,545.00	11,833.00	3.98	0.27	43,825.93
Female-to-Male (FTM)*	20,107.00	9395.00	3.98	0.27	34,796.30
10-Year Time Horizon					
No Health Benefit	23,619.00		6.49		
Provider Coverage	31,816.00	8197.00	7.37	0.88	9314.77
Male-to-Female (MTF)*	33,034.00	9415.00	7.37	0.88	10,698.86
Female-to-Male (FTM)*	30,597.00	6978.00	7.37	0.88	7929.55

(*) Compared to no health benefit; QALY quality-adjusted life year

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Hormone Therapy

Insurance Coverage and Coding Considerations in Gender Affirming Hormonal Care for Adolescents & Young Adults

Stephen M. Rosenthal, MD
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child & Adolescent Gender Center
University of California – San Francisco

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Objectives

- Review basics of hormone action and regulation of puberty
- Understand use of pubertal blockers and gender-affirming sex hormones (GAH)
- Understand mental health benefits of gender-affirming hormonal care, some of which may be life-saving
- Understand relevant coding for pubertal blockers and GAH

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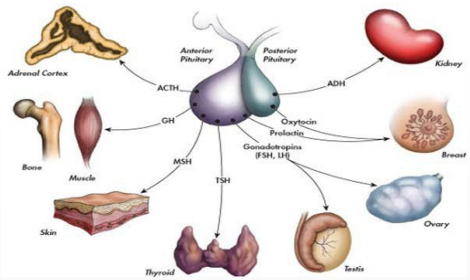
What is a hormone?

A chemical substance made in one part of the body that has effects in other parts of the body



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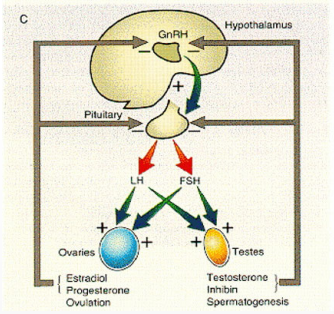
Hormonal Regulation of Puberty:

Sexual Maturation & Attainment of Reproductive Capability



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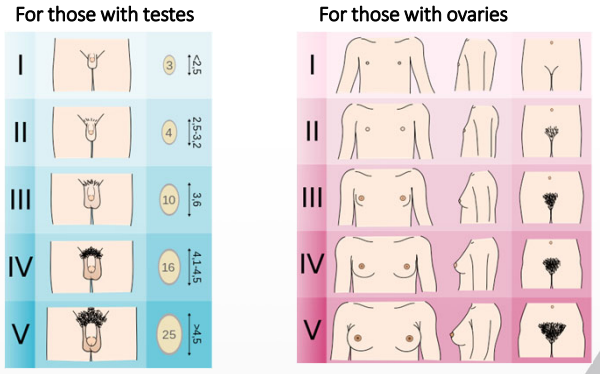
Physical Stages of Puberty:



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Children & Adolescents with Gender Dysphoria: Natural History

- Gender Dysphoria emerging at puberty or persisting into early puberty:
  - Likely transgender as adult

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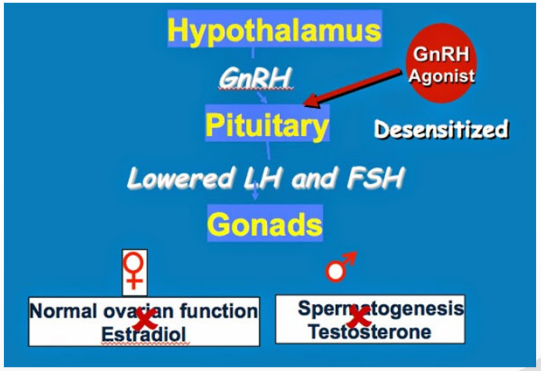
What are Puberty Blockers and what is their indication for use?



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Puberty Blockers

- Put puberty on pause; "buy time"
- Prevent experiencing physical changes of puberty of undesired sex
- Fully reversible
- Once puberty completed, can only be incompletely reversed—making it difficult to blend in/ be seen as affirmed gender
  - Testosterone: Low voice, Adam's apple; facial features
  - Estrogen: Breast development

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Gender-Affirming Hormonal Management of Adolescents

- WPATH Standards of Care (SOC) 7
- Endocrine Society Clinical Practice Guideline
  - Co-sponsored by WPATH
- Puberty blockers
  - Gender dysphoria has emerged or worsened with onset of puberty
- Gender-affirming sex hormones (Estradiol, Testosterone)
  - Initiate around age 16 yr
  - May be initiated before age 16 yr on case-by-case basis

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Scientific Evidence Supporting Use of Pubertal Blockers and GAH in Adolescents

- Seminal study from Netherlands—Mental Health outcomes:
  - Following treatment with puberty blockers, GAH, and gender-affirming surgery:
    - Gender Dysphoria resolved
    - Psychological functioning generally improved
    - Sense of "well-being" equivalent or superior to age-matched controls from general population
    - No patients reported regret at any stage of treatment
- Seminal studies from U.S. —Mental Health outcomes:
  - Individuals treated with puberty blockers had significantly lower odds of lifetime suicidal ideation compared to those who wanted access to such Rx but didn't receive it.
  - Pubertal blockers and GAH Rx associated with improved body image and significant decreases in body dissatisfaction

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CPT & ICD -9/10 codes in the care of Transgender/ Gender diverse Adolescents

- CPT codes for endocrine consultation
  - New
    - Level of medical complexity
    - Time spent face-to-face with patient with >50% focused on management
  - Follow-up
    - Level of medical complexity
    - Time spent face-to-face with patient with >50% focused on management
- **ICD 9/10 codes**
  - **Gender Dysphoria: F64.0**
  - **Endocrine disorder-NOS: 259.9/E34.9**
- CPT procedure codes
  - Placement of puberty blocker implant (histrelin)--11981
  - Removal of puberty blocker implant--11982
  - Removal of puberty blocker implant with reinsertion—11983
  - Administration of puberty blocker by injection (leuprolide; triptorelin)
  - Administration of subcutaneous testosterone pellets
- Codes for Rx
  - Histrelin implant
  - Leuprolide; triptorelin injection
  - Estraiol: patch, pills, injection
  - Testosterone: injection, transdermal (patch; gel), subcutaneous pellets

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Insurance Reimbursement Challenges in the Medical Care of Transgender/ Gender diverse Adolescents

- **Primary Challenge:**
  - **Reimbursement for GnRH agonists/ Pubertal blockers**
    - Implant: Histrelin
    - Injection: Leuprolide; triptorelin
  - **"Labeling concern"**
    - Not FDA-labeled for use for adolescents with gender dysphoria
    - Only FDA-labeled use in pediatric context: precocious puberty
  - **Despite "Off-label" context, GnRH agonists/ Pubertal blockers are the Standard of Care in the management of early-mid-pubertal gender dysphoric adolescents**
    - as detailed in the WPATH SOC7 and the Endocrine Society Clinical Practice Guideline (co-sponsored by WPATH)

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Mental Health

Gender Affirming Mental Health Services

WPATH Training on current standards in mental health treatment, outcomes, and access to care for Gender dysphoria associated with Gender incongruence

Presented by Dr. Shawn V. Giammattei

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Disclosures

None

Disclaimer

CPT & Diagnostic codes listed in this presentation present the most frequently utilized. The types of mental health services provided will differ depending on the specialty of the provider and the needs of the patient.

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Content

- The Roles of Mental Health Providers and common codes
- Gender Health Evaluations and Standards of Care, Version 7[1]
  - Symptoms & Diagnosis
    - Meeting criteria or not
    - Coding
- Understanding Gender Dysphoria
  - Impact on Mental Health & Quality of Life
  - Internal vs External Factors
- Outcomes of Mental Health & Medical Treatment
- Mental Health & Access to Care

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Common Roles for Mental Health Providers

- ***Individual Therapist (child/adolescent/adult)***
- ***Family / Couple Therapist***
- ***Group Therapist (in or out of treatment facility)***
- ***Gender Health Evaluator / Letter Writer***
  - ***Collaborator in living authentically***
- ***Gender Educator/Advocate***
- ***Gender Coach***

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Mental Health CPT Codes

Procedure	CPT Codes
Intake / Diagnostic Interview	90791
Individual 20-37 min session (tele-therapy)	90832, (90832-95)
Individual 38-52 min session (tele-therapy)	90834, (90834-95)
Individual 52+ min session (tele-therapy)	90837, (90837-95)
Add on for Complexity	90785
Crisis Session 60 min (tele-therapy)	90839, (90839-95)
Crisis Session add on 30 min (tele-therapy)	90840, (90840-95)
Family Session without patient (tele-therapy)	90846, (90846-95)
Family/Couples Session w/patient (tele-therapy)	90847, (90847-95)
Group Therapy	90853
Psychological Evaluation (add-on)	96130, (96131)
Clinical Consultation	90785

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Gender Health Evaluations & SOC7

Purpose:

- Assess Gender Dysphoria & Refer for treatment as necessary
  - Psychosocial assessment:
    - Gender history
    - Assess, diagnose, and discuss treatment for co-occurring issues
    - Assess ability to consent to treatment
  - Gender Psychoeducation
    - Different identities and presentations
    - possible interventions
    - Assess eligibility for medical treatments (hormones/surgery)
  - Create a social/medical/legal/psychological treatment plan
    - Make referrals for medical treatments
    - Prepare for medical interventions (pre & post care)

(Coleman et al, 2011)

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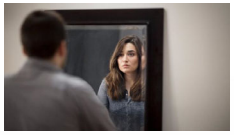
Gender Dysphoria – The Experience

- **Mental Map**



- **Social Mirror**
  - Pronouns
  - Name
  - Toys/ expectations

- **Physical Mirror**
- **Existential Panic**
- **Gender Noise**

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Gender (Dysphoria) Noise

- ***Non-stop narration***
  - It goes beyond body dysphoria
  - Cacophonous
  - Intrusive
  - Volume changes based on context
    - Never fully goes away

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Gender (Dysphoria) Noise

- ***Often involves:***
  - Fears about safety
  - how others see you or will react to you
  - how you sound
  - how you walk. talk, gesture
  - Making sense of microaggressions

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Factors that Influence Health Disparities

- **Internal Experiences**
  - Gender Dysphoria
  - Co-occurring Mental Health Issues not related to minority stress
  - The internalization of negative attitudes
- **External Experiences**
  - *Misgendering*
  - *Minority Stress* (potential or experienced discrimination, oppression, violence, etc.)
  - *Family /Community Support* (or lack of support)
    - stressors resulting from rejection, maltreatment, harassment, discrimination, and a transphobic society
  - *Employment/housing/food insecurities*

(James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016; Hendricks & Testa, 2012)

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DSM Diagnosis of Gender Dysphoria

Criterion A:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two or more of the following:

Criterion B:

- The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Full Criteria for Gender Dysphoria may not be currently present, yet treatment may be medically necessary

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Mental Health Diagnostic Codes

Diagnosis	ICD Code (DSM Code)
Gender Dysphoria in Adolescents and Adults (Transsexualism)	F64.0 (302.85)
Gender Dysphoria in Children	F64.2 (302.6)
Other Specified Gender Dysphoria	F64.8 (302.6)
Unspecified Gender Dysphoria	F64.9 (302.6)

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Impact on Mental Health/Quality of Life

US National Transgender Study

- 39% experienced serious psychological distress in the month prior to completing the survey, compared with only 5% of the U.S. population.
- 40% of respondents have attempted suicide in their lifetime—nearly nine times the attempted suicide rate in the U.S. population (4.6%).
- 33% who saw a health care provider had at least one negative experience related to being transgender
- 23% did not seek the health care they needed in the year prior due to fear of being mistreated as a transgender person
- 33% did not go to a health care provider when needed because they could not afford it.

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(James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016)

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Impact on Mental Health

(Across multiple studies)

- High Rates Depression
  - 44 % - 84 % trans and non-binary people had clinical depression
  - Rates increase with intersections of marginalized identities and age
- High Rates of Anxiety
  - 45% -90% of TGNB people experienced clinically significant anxiety
- Suicidality
  - 40%-50% had attempted suicide
- Self-harming behavior
  - 19%-43% had engaged in self-injurious behavior.

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(Budge, Adelson, & Howard, 2013; James et al, 2016; Veale et al, 2017; Becerra-Culqui et al, 2018))

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Common Co-Occurring Mental Health Issues

- Autism 3 to 6 times more likely
- ADHD
- OCD
- Eating Disorders – 18% vs 1%
- Social Phobia (anxiety)
- PTSD
- Substance Mis-use

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Main Factors that Influence Mental Health and Quality of Life

(excluding discrimination/violence/oppression)

- Family Support
  - Support from family is protective against depression, and significantly associated with a higher quality of life and decreased perceived burden about being transgender
- Mis-alignment & Misgendering vs Authenticity
  - Navigating a world in a body that doesn't align or is read as trans vs being mirrored as your authentic self.
- Medical treatment and the impact of not receiving care/coverage.
  - Medical necessity of alignment to bring one's body into a normal healthy state given their affirmed gender.

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(Katz-Wise et al., 2016; Ryan et al., 2010; Simons et al., 2013).

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Outcomes Related to Social/Medical Interventions

Across the board improvements in mental health and quality of life

- Significant reduction in depression, anxiety, self-harm, suicidality, and substance abuse.
- Prepubertal children who socially transition have similar levels of difficulties as their cisgender peers
- Improves body image, well-being, and decreases gender dysphoria
- Improved quality of life, greater relationship satisfaction, higher self-esteem and confidence
- Hormone therapy was associated with increased QOL, decreased depression, and decreased anxiety across Identity and age.
- Pubertal suppression reduces odds of suicidality, anxiety & depression

(Olson et al, 2016; Passos et al, 2019; Becker et al, 2018; Poudrier et al,2019; Tomita et al 2019)

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Factors that Improve Success in the Treatment of Gender Dysphoria

- Adequate preparation and mental health support prior to treatment
- Proper follow-up care from knowledgeable providers
- Consistent family and social support
- Positive surgical outcomes (when surgery is involved)
- Access to care

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Common Roadblocks in Access to Care
(Insurance)

- Coverage for Transgender Health
- Finding out what's covered
- Access to providers
  - Having providers on panels that know how to do Gender Health Evaluations
  - Single Case Agreements
  - Issues with search criteria – when a specialist is needed

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Common Roadblocks in Access to Care
(Children & Families)

- Finding providers that understand child development, co-occurring childhood issues, and gender development for gender expansive youth
- Coverage for family/parenting sessions
- Access to GnRH agonists (puberty suppression)
  - Impact of onset of puberty or potential onset
- Advocacy / Consultations with schools

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Common Roadblocks in Access to Care
(Adolescents)

- Limits on types of therapy (Family Therapy)
- Fertility preservation when starting hormones
- Surgical interventions (Age limits)
  - Male chest reconstruction
  - Less common
    - Tracheal shave
    - Breast augmentation
    - Genital surgery

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Common Roadblocks in Access to Care
(Adults)

- Family/Couples Therapy
- Fertility preservation when starting hormones
- Voice Therapy
- Electrolysis
- Surgical Interventions
  - Facial Feminization/Masculinization
  - Tracheal Shave
  - Breast Augmentation
  - Vocal Cord Surgery

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Thank You!

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Fertility

Fertility Preservation: Clinical & Coverage Concerns

Paula Amato, MD, Oregon Health & Science University
Joyce Reinecke, JD, Alliance for Fertility Preservation

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Disclosures

None

Disclaimer

The codes given in this presentation are codes for fertility preservation and laboratory procedures compiled by the ASRM Coding Committee. The CPT codes listed are standard for ART procedures. While we have listed codes relevant to fertility preservation, this list is not exhaustive of all procedures.

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Gender Transition and Fertility

Everyone should understand fertility preservation options before beginning medical transition to consider how to protect fertility.

WPATH and the Endocrine Society both recommend that all transgender patients be counseled regarding the options for fertility preservation prior to transition.

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3

Fertility in Trans Communities

- Not enough research and data on fertility preservation in transgender communities
- Many transgender persons desire children
  - 62% of transmen (Wierckx et al, '12)
- Cross-hormone therapy and gender-affirming surgery (eg. gonadectomy) may result in loss of fertility; may be reversible or irreversible
- The majority of transgender persons are of reproductive age at the time of transition and have relationships after transition

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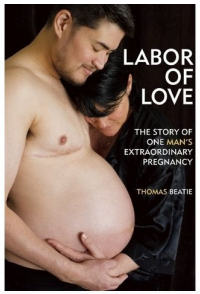
4

Imagining Parenthood

Public attention regarding transgender pregnancy and parenting surged in 2009 with Thomas Beatie's story

Became pregnant via donor insemination while married to a woman

Has 3 children



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Health Considerations

Factors in successful fertility preservation and reproduction:

Age
Diet and nutrition/weight
Smoking
Alcohol and drug use
History of STI's
Previous reproductive problems

6

Timing and Decision-Making

Fertility preservation and reproduction can look different before initiation of medical transition then after transition

Talking with a mental health or medical professional, or peer support to determine impact of fertility preservation or reproductive treatments on gender dysphoria is recommended

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Transfeminine Fertility Preservation Options

- Sperm cryopreservation
- Testicular sperm extraction (TESE)
- Testicular tissue preservation
  - experimental in prepubertal boys

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Transmasculine Fertility Preservation Options

- Oocyte and/or embryo cryopreservation
  - using partner or donor sperm
  - success rate is age-dependent and freeze method-dependent e.g., vitrification vs. slow freeze
- Ovarian tissue cryopreservation
  - No longer "experimental"
  - several live births worldwide
- In-vitro oocyte maturation (experimental)

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Reproductive Options for Transgender Persons

- Usually requires discontinuation of exogenous hormones (unless using cryopreserved gametes in a partner) (how long?)
- Time to return to fertility is variable; may be irreversible
- Impact of a history of long-term exogenous hormone exposure on gametes and/or resulting offspring is unknown

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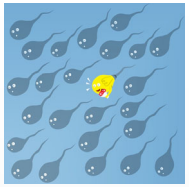
10

Trans Masculine Reproductive Options

- IUI (using partner or donor sperm)
- IVF (using own or partner's eggs; using own or partner's uterus or GC)



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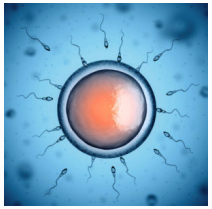
Trans Feminine Reproductive Options



- IUI of partner with a uterus
- IVF using partner or donor eggs/sperm and/or partner's uterus or GC
- Uterine transplantation in the future?

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ASRM & FDA Guidelines: Gamete Donation

- Medical history and physical exam
- STI testing
- Risk factor questionnaire
- Psychological counseling

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Access to Fertility Services

- No data on transgender persons specifically
- Non-discrimination laws vary by jurisdiction

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Ethical Considerations in Family Building

Reproductive autonomy
Well-being/interest of the offspring
Safety of procedures/treatments
Impact on society

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Perinatal, Pregnancy, and Parenting Issues

- Web-based survey
- 41 transmen; 61% had used T
- 80% resumed menses w/in 6 months
- 88% cases used own eggs
- 2/3 of pregnancies were planned
- 7% used fertility meds
- Similar OB outcomes in T and non-T users
- Desire for supportive resources
- Lack of provider awareness and knowledge

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Clinical Summary

- Many transgender persons desire children and are of reproductive age at the time of transition
- Transgender persons should be offered fertility preservation prior to cross-sex hormone therapy and gender-affirming surgery
- Transgender persons should have access to fertility services
- Multidisciplinary team approach
- Research should be encouraged

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Defining fertility preservation

Fertility preservation is the process of saving or protecting eggs, sperm, or reproductive tissue so that a person can use them to have biological children in the future.

-AFP and NICHD

Iatrogenic Infertility: An impairment of fertility by surgery, radiation, chemotherapy or other medical treatment or intervention affecting reproductive organs or processes.

- Potential side effect of necessary medical treatment
- Underlying diagnosis for another disease or condition
- Does not include:
  - "Elective" egg freezing for naturally arising diminished ovarian reserve or aging
  - Treatment for a diagnosis of infertility itself, e.g., procedures/medications to cause a pregnancy such as IUI or IVF

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Who needs fertility preservation?

Trans Population:
- Before gender-affirming surgery; removal of the testicles or ovaries causes permanent infertility
- Possibly before beginning cross-hormone therapy; may cause temporary infertility, but long-term fertility impacts not known; FP later would require cessation of hormone treatment and possible psychological distress

Cancer Patients:
- Before chemotherapy, radiation, and/or surgery affects gametes and/or reproductive organs
- Maintenance therapies and/or late effects of treatment may create incompatibility with pregnancy

Others at risk:
- Sickle cell disease or some hematologic conditions especially if bone marrow transplant is required
- Prior to prophylactic surgery, e.g., oophorectomy; hysterectomy
- Emerging: to screen and avoid genetic conditions

Studies:
- In trans and cancer populations: participants identify genetic parenthood as a concern
- In young adult cancer survivors, unaddressed infertility is associated with higher levels of anxiety, depression, and lower Q of L

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How much does Fertility Preservation cost?

Fertility Procedure/Option	Average Cost
Oocyte/Embryo Cryopreservation	$10,000 - $15,000
Ovarian Tissue Cryopreservation*	$10,000 - $12,000
Sperm Banking/FDA Testing	$1,000
Testicular Tissue Freezing**	$2,500
Intrauterine Insemination (IUI)	$400
In Vitro Fertilization (IVF) (Cycle)	$15,000
Donor Sperm (Vial)	$400
Donor Oocytes	$25,000
Gestational Surrogacy	$50,000 - $100,000+

**ASRM removed experimental label in Dec. 2018*
*** Still classified as "investigational"*

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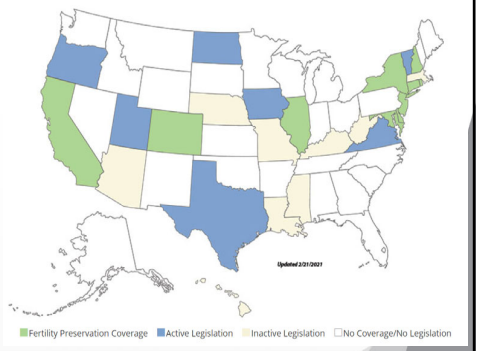
Legislative Summary 2017-to DATE

31+ M Lives Covered!

11 States Have Enacted FP Coverage:

California	New Hampshire*
Connecticut	New Jersey
Colorado*	New York*
Delaware*	Rhode Island
Illinois	Utah**
Maryland	

*Also includes IVF coverage
**Medicaid; for cancer patients only



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California Coverage

- 1st state to add stand-alone FP coverage
- Based on state law: Knox Keene Act
- Insurers must cover BASIC HEALTH CARE SERVICES
- Bill "clarifies" existing coverage for those at risk for iatrogenic infertility

Los Angeles Times

Fertility options for cancer patients must be covered under new California law

By MELODY GUTIERREZ | STAFF WRITER OCT. 13, 2019 | 8:02 AM

SACRAMENTO – California will require health insurance companies to cover the cost of fertility procedures for patients undergoing treatment that can make it difficult to have children, such as chemotherapy, under a bill signed by Gov. Gavin Newsom on Saturday.

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SB 600

SENATE BILL No. 600

Introduced by Senator Portantino

February 22, 2019

An act to add Sections 1374.551 and 1374.552 to the Health and Safety Code, and to add Sections 10119.61 and 10119.62 to the Insurance Code, relating to healthcare coverage.

- Signed into law October 19, 2019
- Not a new mandate, but rather a codified existing law
- Categorized *fertility preservation* services as distinct from *infertility services*
- Only affected DMHC plans
  - Did not include Medi-Cal
  - Did not include self-insured ERISA plans

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SB 600 - Language

- **SECTION 1.**
- Section 1374.551 is added to the Health and Safety Code, to read:
- **1374.551.**
- (a) When a covered treatment may directly or indirectly cause iatrogenic infertility, standard fertility preservation services are a basic health care service, as defined in subdivision (b) of Section 1345 and are not within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55.
- (b) For purposes of this section, the following definitions apply:
- (1) "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.
- (2) "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- (3) "Standard fertility preservation services" means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

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Iatrogenic Infertility

- *"Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.*

Surgery:
- Oophorectomy and/or Hysterectomy
- Orchiectomy

Other medical treatment:
- Cross-sex hormones

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Side Effect

- *"May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.*

Updated in 2021:
Exogenous hormones and gonadectomy have well recognized impacts on fertility, and providers may encounter patients seeking fertility preservation and/or assisted reproduction.

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"Standard" Procedures

- *"Standard fertility preservation services" means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.*

Updated in 2021:
Fertility preservation options include sperm, oocyte, and embryo cryopreservation as well as ovarian tissue cryopreservation. Prepubertal testicular tissue cryopreservation is considered investigational.

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Details of Coverage

- Scope of coverage includes all procedures and medications that are "medically necessary" for fertility preservation
- Fertility consultation
- Sperm analysis, banking, and freezing
- Ovulation induction, monitoring, oocyte retrieval, freezing of oocytes or fertilization and freezing of embryos
- Storage of frozen tissues
- Specifics of coverage not established:
- Number of sperm specimens banked;
- Number of egg maturation and collection cycles;
- Medications;
- Lab work; embryology; screening of embryos, etc.
- Duration of storage

DMHC regulations pending

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Fertility preservation coding

Two codes are available to practitioners for billing in these scenarios. Z codes are a special group of codes provided in ICD-10-CM for the reporting of factors influencing health status and contact with health services. The diagnosis is included as a Z code because the actual code for the underlying cancer diagnosis cannot be used while counseling or providing management for fertility preservation.

Z31.62 Encounter for fertility preservation counseling
This code includes encounter for fertility preservation *counseling* prior to cancer therapy and prior to surgical removal of gonads. Although the wording as above may imply cancer treatment or removal of gonads, these are meant as examples and this code can be used for elective fertility preservation for non-cancer or surgical removal of gonads patients as well. This code should be used whenever an E/M component is involved, such as initial visit or subsequent counseling/management visits.

Z31.84 Encounter for fertility preservation procedure
This code includes encounter for fertility preservation procedure prior to cancer therapy and prior to surgical removal of gonads. As noted above, although the wording may imply cancer treatment or removal of gonads, these are meant as examples and this code can be used for elective fertility preservation for non-cancer patients as well. This code should be used whenever a procedure is being performed such as egg retrieval or oocyte culture.

Any other relevant diagnosis code should be used (ASRM Coding Cmte)

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FP and ART CPT codes

Advanced Reproductive/Fertilization Services	CPT Codes
Cryopreservation, mature oocyte(s)	89337
Cryopreservation; immature oocyte(s)	0357T
Cryopreservation; embryo(s)	89258
Cryopreservation; sperm	89259
Cryopreservation; reproductive tissue, ovarian	0058T
Cryopreservation; reproductive tissue, testicular	89335
Follicle puncture for oocyte retrieval, any method	58970
Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	76948
Culture of oocyte(s)/embryo(s), less than 4 days	89250
Culture of oocyte(s)/embryo(s), less than 4 days; with co - culture of oocyte(s)/embryos	89251
Assisted embryo hatching, microtechniques (any method)	89253
Oocyte identification from follicular fluid	89254
Sperm identification from aspiration (other than seminal fluid)	89257
Sperm identification from testis tissue, fresh or cryopreserved	89264
Extended culture of oocyte(s)/embryo(s), 4 - 7 days	89272

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FP and ART CPT codes

Ovulation Induction	CPT Codes
Injection, chorionic gonadotropin, per 1,000 USP units	10725
Injection, urofollitropin, 75 IU	J3355
Injection, menotropins, 75 IU	S0122
Injection, follitropin alfa, 75 IU	S0126
Injection, follitropin beta, 75 IU	S0128
Injection, ganirelix acetate, 250 mcg	S0132
Management of ovulation induction (interpretation of diagnostic tests and studies, non face-to- face medical management of the patient), per cycle	S4042

Storage (per year)	CPT Codes
Storage; oocyte(s)	89346
Storage; embryo(s)	89342
Storage; sperm/semen	89343
Storage; reproductive tissue, testicular/ovarian	89344

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Rationales for Coverage

1. Fertility Preservation is *Medically Necessary*
2. Treatments are *Standard of Care*
3. Low Cost & Potential Cost Offsets
4. Ethical Bases for Coverage

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THANK YOU

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joyce@allianceforfertilitypreservation.org

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Surgery

Gender Affirming Surgery

WPATH Training on current standards in surgical treatment for gender dysphoria associated with gender incongruence

Presented by Dr. Loren Schechter & Dr. Jens Urs Berli

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Disclosures

None

Disclaimer

CPT codes listed in this presentation are the most frequently utilized. As surgeries can differ depending on clinical situation and surgeon approach and as surgeries evolve, other CPT codes may be submitted by individual providers.

Surgical assistants and/or co-surgeons may be required for various procedures

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Content

- Overview of multi-disciplinary care team and their roles
- Preoperative Evaluation and Standards of Care, Version 7[1]
- Surgeries
  - Overview
  - Basic description
  - Variations and Staging
  - Coding

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Coleman, E et al. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165–232.

3

Surgical Providers* (surgical assistants and/or co-surgeons may be required based on the procedure and/or clinical circumstances)

Specialty	Facial Feminization	Chest Feminization	Feminizing Genital Surgery[1]	Voice Surgery	Body Contouring	Facial Masculinization	Chest Masculinization[1]	Masculinizing Genital Surgery	Body Contouring
Plastic Surgery	●	●	●		●	●	●	●	●
Reconstructive Urologist			●					●	
Gynecologist			●					●	
Fertility			●					●	
ENT	●			●		●			
OMFS	●					●			

[1] Including Gonadectomy or Hysterectomy and/or sperm/oocyte preservation
* Other surgeons and/or consultants may be required on an as needed basis (ie colorectal surgeon)

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Other Providers directly related to GAS*

Specialty	Facial Feminization	Chest Feminization	Feminizing Genital Surgery	Voice Surgery	Body Contouring	Facial Masculinization	Chest Masculinization	Masculinizing Genital Surgery	Body Contouring
Mental Health & Social Work	●	●	●	●	●	●	●	●	●
Electrologist / Dermatologist	●		●					●	
Physical Therapy[2]		●	●					●	
Occupational Therapy								●	
Speech Language Pathologist			●	●					
Radiology	●	●	●			●		●	
Pathologist			●				●	●	
Allied Health Professional (NP, PA, etc)	●	●	●	●	●	●	●	●	●

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2) Jiang DD et al. Implementation of a Pelvic Floor Physical Therapy Program for Transgender Women Undergoing Gender-Affirming Vaginoplasty. Obstet Gynecol. 2019 May;133(5):1003-1011

* Other professionals may be required on an as needed basis

5

Medically Necessary SOC 7 vs. SOC8

	Facial Feminization	Chest Feminization	Feminizing Genital Surgery	Voice Surgery	Body Contouring	Facial Masculinization	Chest Masculinization	Masculinizing Genital Surgery	Body Contouring
SOC 7	●	●	●				●	●	
SOC 8	●	●	●			●	●	●	●

● Generally considered medically necessary / reconstructive

● Depends upon clinical scenario

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1) Coleman, E et al. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165–232.

6

Preoperative Evaluation Standards Across Disciplines

Requirement	Facial Feminization	Chest Feminization	Feminizing Genital Surgery[1]	Voice Surgery	Body Contouring	Facial Masculinization	Chest Masculinization[1]	Masculinizing Genital Surgery	Body Contouring
Mental Health Letter x1		●					●		
Mental Health Letter x2			●					●	
Hormones >12 months (if indicated/desired)		●	●					●	
Hormones 6 months (if indicated/desired)							●		
Social Transition >12 months			●					●	
Age of majority			●					●	

● Recommended not required

● Within clinically appropriate context, may be performed under the age of 18

[1] Gonadectomy alone does not require social transition for 12 months

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Common issues in gender-affirming surgery

- Use of gendered codes (with discordance between cpt code and gender markers)
- Staged and/or revision procedures do not require resubmission of assessment letters (unless clinically indicated)
- Denial of medically necessary codes
  - Nipple-areola reconstruction in chest masculinizing surgery
  - Skin graft codes in vaginoplasty
- Approval for Skilled Nursing Facility (SNF) follow surgery
- Age-related denials for medically necessary procedures
  - Mastectomy under the age of 18 yrs
- Epilation (i.e., electrolysis/laser hair removal) is medically necessary (CPT codes 17380, 17999)
  - Vaginoplasty
  - Phalloplasty
  - Facial Surgery

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Feminizing Surgeries Overview

- Facial Feminization Surgery
- Chest Feminization
- Orchiectomy
- Vulvoplasty (0-depth vaginoplasty)
- Vaginoplasty
  - Penile Inversion Vaginoplasty
  - Robotic assist Vaginoplasty
  - Intestinal Vaginoplasty
- Body Contouring
- Voice Surgery

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Facial Feminization Surgery

Indication:

AMAB (assigned male at birth) individuals with facial gender markers incongruent with their gender identity

Internal Response to Gender Incongruence

External Response to Gender Incongruence

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Multimodal and multi-disciplinary approach

- Mental Health (specific to FFS)
  - Understanding expectations
  - Management of postoperative care
  - Societal response / mental health impact of persistent misgendering
- Gender Expression / Styling
- Hair removal (!)
- Effects of exogenous hormones
- Surgeries -> Structural & Soft Tissue

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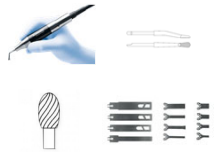
Surgeries Structural



Methods:

- Ostectomy
- Osteotomies with refixation in new position
- Osteoplasty by burring/rasping
- Alloplastic augmentation (silicone, medpore)
- Autologous augmentation (bone from separate site vs. cadaveric)
- Cartilage excision, reshaping, repositioning
- 3D Virtual surgical planning (CPT 76377)

Intent:

- Alteration of vertical (ver), horizontal (hor) or antero-posterior dimensions (ap).
- Either through augmentation (aug) or reduction (red).

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Soft Tissue Surgeries

Methods:
- Skin, fat excision
- Liposuction
- Fat grafting, fillers
- Adjacent tissue transfer

Intent:
- Reverse iatrogenic soft tissue ptosis
- Augment by addition of volume in certain areas (e.g. lips, cheeks)

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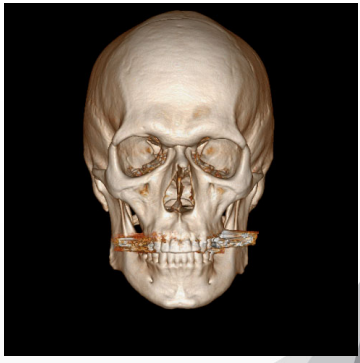
Surgeries Structural



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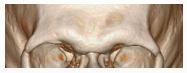
Structural Surgeries Upper Third



Osteoplasty forehead	CPT Codes
Frontal bone reduction a/p	21209 21137 Modifier 22
Temporal crest reduction	
Orbital rim red (a/p + ver)	
Zygomaticofrontal red (ap)	

Osteotomy forehead	CPT Codes
Frontal sinus set back	21139

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Soft Tissue Surgeries Upper Third

Forehead feminization	CPT Codes
Brow lift	67900
Reduction of forehead height (ver)	14021, 14060, 14301, 14302

Others	CPT Codes
Blepharoplasty Upper	15822
Blepharoplasty Lower	15822
Fat grafting (temporal)	15773
Temporal augmentation • Fatgrafting • Dermal grafts • Alloplastic	15773 15770 21208

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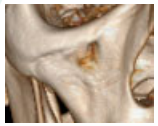
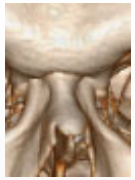
Structural & Soft Tissue Middle Third





Cheek Augmentation	CPT Codes
Midface osteotomies (rare)	21188, 21141-7
Cheek implant	21270
Fatgrafting	15773

Nose and upper lip	CPT Codes
Rhinoplasty Incl. cartilage harvest	3400/10/20 20912, 21235
Septoplasty	30520, 30465
Liplift (red ver)	14060-1
Fat grafting	15773
Rhytidectomy	15828-9

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Structural Surgeries Lower Face

Chin	CPT Codes
Genioplasty aug vertical (graft/prosth)	21120
Genioplasty, sliding (ap)	21121
Genioplasty, multiple (ap/hor)	21122

Jawline (bilateral modifier 50)	CPT Codes
Mandibular bone ostectomy (ver/hor)	21025, 21193
Mandibular osteoplasty (ver/hor)	21209
Liplift (red ver)	14060-1
Liposuction neck	15876
Rhytidectomy	15828-9

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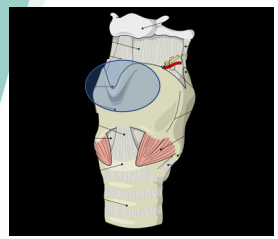
Structural Surgeries Neck



Larynx	CPT Codes
Laryngeochondroplasty	31750, 31599
Voice Feminization	31599

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Chest Feminization Surgery

Indication:

AMAB (assigned male at birth) individuals with gender dysphoria due to insufficient breast tissue.

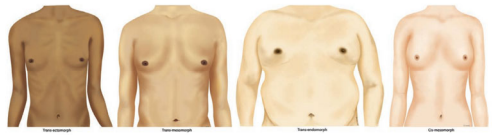

Fig. 1. Illustration of all 3 body type classifications in transgender patients, compared with the most common cis-mesomorph body type.

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Nauta AC et al. Differences in Chest Measurements between the Cis-female and Trans-female Chest Exposed to Estrogen and Its Implications for Breast Augmentation. Plast Reconstr Surg Glob Open. 2019 Mar 13;7(3):e2167.

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Chest Feminization

Mammaplasty (MP)	CPT Codes
Mammaplasty with implant	19325
Mammaplasty with fat grafting	20926
Capsulotomy, capsulectomy	19370, 19371
Use of acellular dermal matrix (capsular contracture)	15777
Immediate breast implant at time of mastopexy, mastectomy, or reconstruction	19340
Delayed insertion of breast implant	19342
Tissue expander in breast reconstruction	19357
Hair removal	17380, 17999

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Orchiectomy isolated

Indication:

AMAB (assigned may at birth) individuals with gender dysphoria who undergo removal of gonads

May proceed with genital surgery at later date (scrotectomy may be performed)

Fertility counseling, if appropriate, provided.

Orchiectomy	CPT Codes
Orchiectomy	54530, 54520, modifier 50
Scrotectomy	55150

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Feminizing Genital Surgery

Indication:

AMAB (assigned male at birth) individuals with gender dysphoria who undergo creation of a vulva and/or vagina.

(The following slides courtesy of Oregon Health & Science University Department of Urology)

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Vulva Defined—Outer anatomy

Parts of the Vulva

- Opening to Vagina = internal canal
- Labia = inner and outer skin folds
- Clitoris = erectile tissue at the top of vulva
- Urethra = opening for urine to exit the body

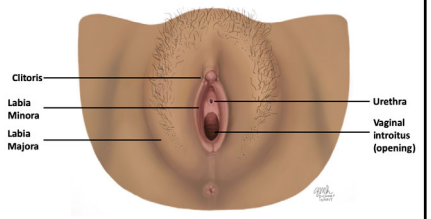

Image created by Zackary Herbst

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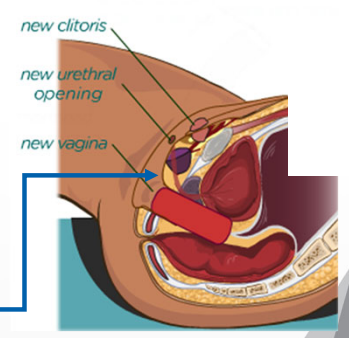
Vaginoplasty Procedure

Inversion of the penis skin tube

The vagina is inserted into the space between the bladder and rectum, and cuts are made to expose the clitoris and urethra in their correct positions.

Vagina with stent inside



Images created by Rebecca Betts

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Vaginal Canal – Lining Options

Penile inversion vaginoplasty (open/perineal)

- Full thickness skin graft uses penile/scrotal tissue as preferred option

Robotic peritoneal flap vaginoplasty

- Still uses penile/scrotal tissue
- While some moisture is created by peritoneum, it's not adequate for self lubrication for sexual activity

Colon

- Colonic flap used for vaginal lining, self moisturized, can have odor, higher morbidity.
- Usually reserved for complex revision surgeries.

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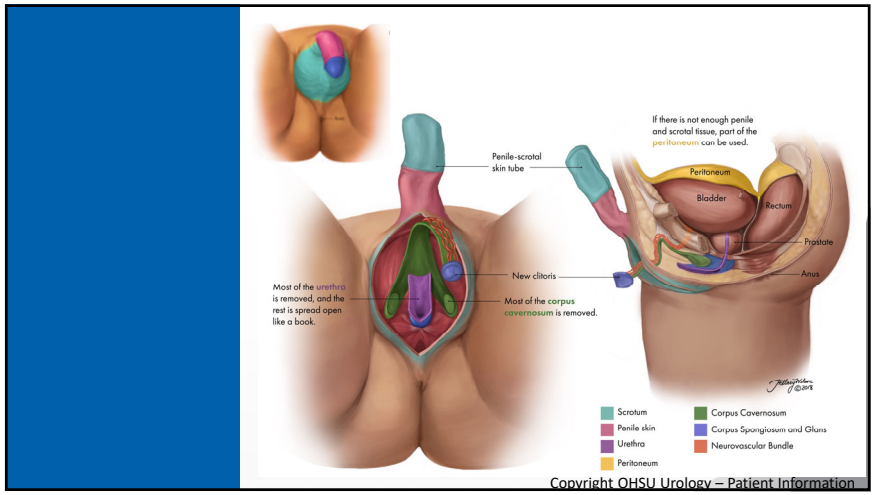

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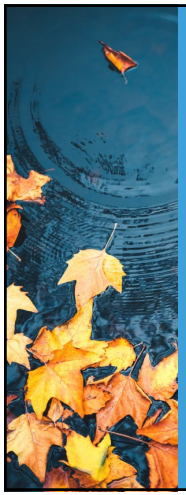

Pelvic Floor Physical Therapy

- Pelvic floor is system of muscles that support urethra, bladder, rectum
- Space for vagina made through these muscles
- Physical therapist who specializes in this part of the body
- Will teach awareness and how to relax muscles that surround entrance to vagina
- Helpful to make dilation easier

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CPT Codes – Vulvoplasty / Vaginoplasty

Tissue Transfer	CPT Codes
Hair removal	17380, 17999
Adjacent tissue transfer	14041, 14301-2
Full thickness skingraft for lining	15240-1
Island pedicled flap (glansplasty flap)	15734, 15740, 15750
Tissue grafts (incl. peritoneal graft)	20926
Urethroplasty	53430
Penectomy	54120, 54125
Orchiectomy	54520, 54530
Introital repair	56800
Clitoroplasty	65805
Construction of vagina, without and with graft	57291-2, 57335
Robotic peritoneal flap vaginoplasty	57355, 49329, 52900
Scrotectomy	55150
Colpopexy	57425
Intersex surgery	55970

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Chest Masculinization Surgery

Indication:

AFAB (assigned female at birth) individuals with gender dysphoria who undergo mastectomy (and/or additional chest contouring procedures such as liposuction) and/or nipple reconstruction.

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Monstrey, Stan M.D., Ph.D. et. al. Chest-Wall Contouring Surgery in Female-to-Male Transsexuals: A New Algorithm, Plastic and Reconstructive Surgery: March 2008 - Volume 121 - Issue 3 - p 849-859

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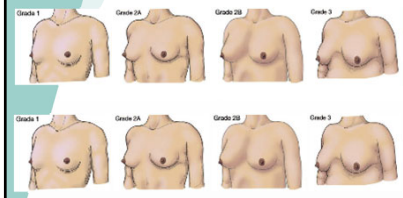
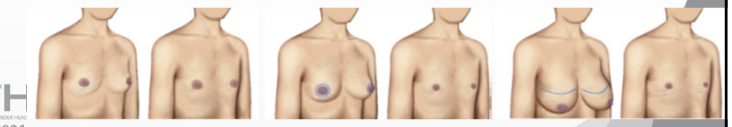
Chest Masculinization



Chest Masculinization including nipple areolar complex (NAC)	CPT Codes
Free full thickness skingraft (NAC)	15200-1
Mastectomy	19303, 19304
Reduction Mammaplasty	19318
NAC reconstruction to masculinize feminine NAC	19350
Adjacent tissue transfer chest	14000-1
Liposuction of chest	15877
NAC tattoo	11920-11922



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Courtesy: Scott Mosser

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Hysterectomy – Salpingo - Oophorectomy

Indication:

AFAB (assigned female at birth) individuals with gender dysphoria who undergo removal of uterus and ovaries either in preparation for genital surgery or in isolation*.

Fertility counseling, if appropriate, provided.

	CPT Codes
Hysterectomy (depending on technique and additional comorbidities) +/- oophorectomy	58XXX

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There may be additional medical reasons for hysterectomy/oophorectomy unrelated to gender dysphoria. The correlation of this procedure with gender dysphoria should not result in a reduction or denial of care/coverage

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Masculinizing Genital Surgery

Indication:

AFAB (assigned female at birth) individuals with gender dysphoria who undergo creation of a phallic structure either by local tissue (plus buccal graft) known as a Metoidioplasty; or by using a combination of local tissue and distant tissue known as a Phalloplasty.

Overlapping CPT codes are often used for masculinizing genital surgery. The next slide provides an overview of various procedural combinations (although combinations may vary between surgeons and depending upon clinical circumstances).

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Masculinizing Genital Surgery (cont.)

Specialty	Simple Metoidioplasty	Complete Metoidioplasty	Shaft Only Phalloplasty	Complete Phalloplasty
Vaginectomy	●	●	●	●
Perineal Urethroplasty		●	●	●
Shaft Urethroplasty				●
Clitoroplasty	●	●	●	●
Perineoplasty	●	●	●	●
Phallic Shaft adult dimensions			●	●
Glansplasty			●	●
Testicular implants	●	●	●	●
Erectile Devices			●	●
Monsplasty	●	●	●	●

● ● Always
● Most often performed
● Based on clinical circumstances

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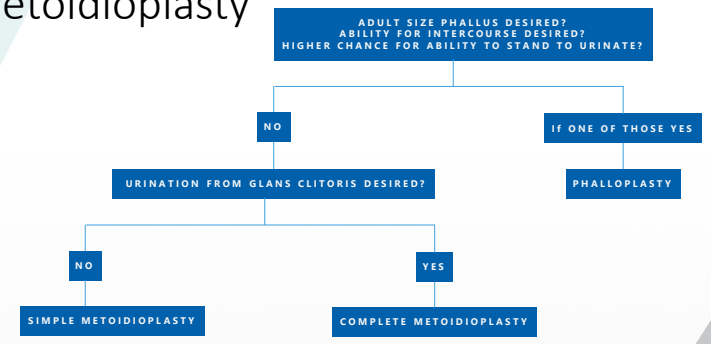
Metoidioplasty



Metoidioplasty may be converted to phalloplasty at later date

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Phalloplasty Simplified

Three main factors determine the surgical path a patient will go when having phalloplasty:

1. Design and composition of tissues
2. Where that tissue comes from
3. Number of stages*

The timing and number of stages may vary. Additional assessments are not required for staged/related/revision procedures

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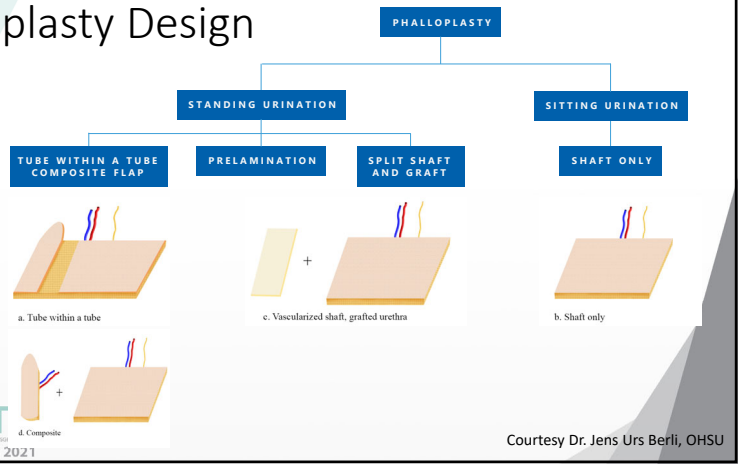
Phalloplasty Design



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Courtesy Dr. Jens Urs Berli, OHSU

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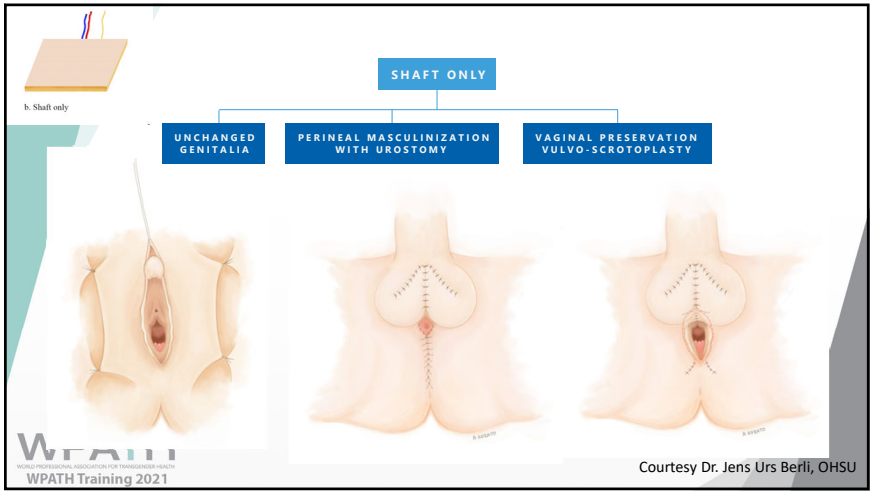

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Courtesy Dr. Jens Urs Berli, OHSU

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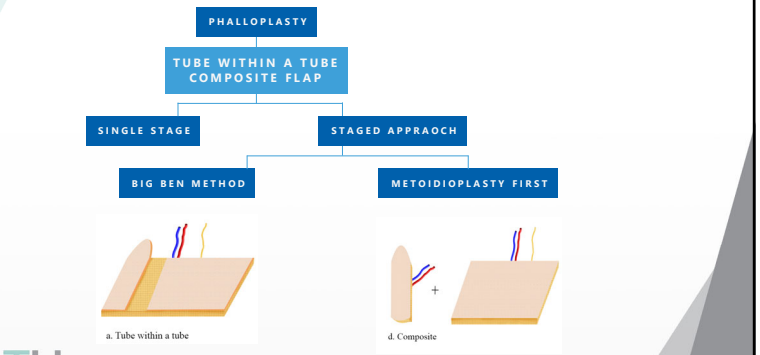

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Courtesy Dr. Jens Urs Berli, OHSU

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Phalloplasty Donor Sites

- Forearm
- Thigh
- Lower Abdomen / Groin
- Back (rare)
- Others

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Courtesy Dr. Jens Urs Berli, OHSU

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Phalloplasty Staging

PROCEDURE	STAGE 1	STAGE 2	STAGE 3	STAGE 4
Classic Phalloplasty	Soft tissue and urological reconstruction	Testicular implants +/- erectile implants		
UK Technique (Dr. Nim)	Creation of neophallus + shaft urethra	Perineal masculinization +/- glansplasty	Testicular implants +/- erectile implants	
Metoidioplasty First	Complete metoidioplasty	Creation of shaft and shaft urethra	Testicular implants +/- erectile implants	
Grafted Urethra	Variety of ways	Variety of ways	Variety of ways	Testicular implants +/- erectile implants

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Danker S, Esmonde N, Berli JU. "Staging" in Phalloplasty. Urol Clin North Am. 2019 Nov;46(4):581-590. doi: 10.1016/j.ucl.2019.07.011. PMID: 31582031.

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CPT Codes – Tissue Transfer/Rearrangement

Tissue Transfer	CPT Codes
Adjacent tissue transfer	14040-1, 14301-2
Split thickness skingraft	15100-1
Full thickness skingraft	15220, 15240
Buccal graft	15115
Skin substitute	15273-4
Fasciocutaneous flap (+/- nerve)	15734, 15738, 15740, 15750 (+ mod 22)
Formation tubed, pedicled flap	15574
Free flap, fasciocutaneous	15751,15757 (+mod 22)

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CPT Codes – Genital Procedures

Tissue Transfer	CPT Codes
Hair removal	17380, 17999
Slit Meatoplasty	53020
Scrotoplasty	55180
Labiaplasty	56620
Vulvectomy	56625
Clitoroplasty	56805
Perinoplasty	56810, 13130-3
Vaginectomy	57110
Colpoclesis	57120
Urethroplasty	53010, 53400, 53405, 53410, 53415, 53410, 53450, 54348, 54352, 54360
Testicular implants (placement and removal)	54660, 55120, 55180
Erectile Devices (placement and removal)	54440, 54405, 54406, 54410, 54415, 54660

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CPT Codes – Other Procedures

Tissue Transfer	CPT Codes
Suprapubic catheter	51102, 51703
Cystoscopy/urethroscopy	52000, 52281
Nerve surgeries	64857, 64856, 64859, 64910
Monsplasty	15839
Fat Grafting	15773
Vacuum assisted wound dressing	97606
Panniculectomy (if pannus/mons precludes phalloplasty)	15830
Gracilis flap	15738
Intersex surgery	55980

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