

Gender-Affirming Treatment Services

GENDER-AFFIRMING TREATMENT SERVICES UNDER THE MARYLAND MEDICAID PROGRAM

Effective January 1, 2024

Policy Statement

The Maryland Medical Assistance Program will provide medically necessary gender-affirming treatment in a nondiscriminatory manner according to criteria consistent with current clinical standards.

Age and Informed Consent Requirements

There are no defined age limits for care. Informed consent is required for all aspects of care. When consent involves a minor, parental consent will be required, and the current Maryland Minor Consent Laws will define who can consent for what services and providers' obligations.¹

Pre-Authorization Requirements

Pre-authorization may be required for certain Medications, Surgical Procedures, and Medical Therapies. Managed care organizations (MCOs) may not be more restrictive than the Fee-For-Service (FFS) Program. This means if there is no pre-authorization requirement from the FFS Program, then MCOs cannot institute a pre-authorization requirement.

- Pre-authorization requirements will be documented on the published FFS Schedule.
- All codes requiring a pre-authorization should have documented clinical criteria requirements.
- Every attempt should be made for providers to consolidate pre-authorization requests for all codes of a multistep procedure.
- The Maryland Medicaid FFS program and the HealthChoice MCOs will provide pre-authorization review and benefit decisions.
- Adverse benefit decisions will be given a final determination by a health care provider with experience prescribing or delivering gender-affirming treatment who has reviewed and confirmed the appropriateness of the determination.

Covered Benefits

1. Hormone Therapy
 - a. Cross Sex Hormone Therapy (Suppression/Replacement)
 - b. Puberty Suppression Therapy
2. Gender Affirming Surgeries and Therapies
3. Post Transition Services
4. Reversal & Revision Procedures
5. Laboratory Testing
6. Behavioral Health Therapy

¹ Maryland Code, Health-General § 20-102, <https://health.maryland.gov/psych/pdfs/Treatment.pdf>.

7. Fertility Preservation Services

Covered Benefits

1. Hormone Therapy

Both Cross Sex Hormone Therapy and Puberty Suppression Therapies may be included. Under federal and state law, only medications approved by the Food and Drug Administration (FDA) and are subject to the Federal Rebate Program are considered for Medicaid coverage. All medications are subject to restrictions outlined in COMAR 10.09.03.05 and COMAR 10.67.06.04. Non-FDA approved medications, over-the-counter medications (OTC) without a prescription, and compounded drugs are not covered by Maryland Medicaid.

a. Cross Sex Hormone Therapy

Continuous hormone replacement and suppression therapy, includes hormones:

- Injected by a medical provider in an office setting, and
- Oral, transdermal, and injectable hormones covered under the pharmacy benefit.

Pre-Authorization: Some codes may require pre-authorization. For specific CPT codes, please refer to the Maryland Medicaid FFS [Fee Schedule](#).

b. Puberty Suppression Therapy

Includes hormones injected by a medical provider in an outpatient setting.

Pre-Authorization: Some codes may require pre-authorization. For specific CPT codes, please refer to the Maryland Medicaid FFS [Fee Schedule](#).

2. Gender-Affirming Surgeries and Therapies

Gender-Affirming Surgeries, when medically necessary, include:

- Gender-affirming genital reassignment surgeries.
- Gender-affirming procedures to the face and neck.
- Gender-affirming procedures related to the: skin, abdomen, chest, trunk, and buttocks.
- Gender-affirming procedures related to hair alterations for the purpose of altering secondary sex characteristics and surgical site preparation.
- Gender-affirming procedures related to voice, voice therapy, and voice lessons.

Pre-Authorization: Required

3. Post Transition Services

Gender-specific post transition services may be medically necessary for transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Pre-Authorization: Not required.

4. **Revision and Reversal Procedures**

Revision and reversal services that may be considered medically necessary for transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals include:

- Revisions of previous gender-affirming surgeries for complications associated with the original procedure (infections or impairment of function).
- Revisions and/or reversals of previous gender-affirming surgeries other than for complications (infections or impairment of function), that meet medical necessity criteria.

The following medical necessity criteria apply to revision/reversal procedures:

- Documentation from the healthcare professional who has evaluated or has been treating the patient, that the proposed revision is medically necessary to address the patient's gender incongruence.
- The surgery or procedure is not for the purpose of reversing the appearance of normal aging.
- The surgery or procedure is specific to feminization, masculinization, or non-binary transition, and would not be pursued for other reasons, e.g., to improve appearance or to correct medical or surgical problems unrelated to feminization, masculinization, or non-binary transition.

Pre-Authorization: Some codes may require pre-authorization. For specific CPT codes, please refer to the Maryland Medicaid FFS [Fee Schedule](#).

5. **Laboratory Testing**

Laboratory testing required for the monitoring of hormone therapy. The benefits are the same as any other outpatient diagnostic service.

Pre-Authorization: Some codes may require pre-authorization. For specific CPT codes, please refer to the Maryland Medicaid FFS [Fee Schedule](#).

6. **Behavioral Health Therapy**

Behavioral health services may be medically necessary for transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals. Examples include **outpatient psychotherapy/mental health services for gender dysphoria and associated comorbid psychiatric diagnoses**. The benefits are the same as any other outpatient mental health services covered under the Maryland Medicaid Behavioral Health benefits.

Pre-Authorization: Not required.

7. **Fertility Preservation Services**

Fertility Preservation Services are procedures that are considered medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is considered to be the impairment of fertility by surgery, radiation, chemotherapy or other medical treatment or intervention affecting reproductive organs or processes. Fertility preservation services are distinct and different from infertility services.

Maryland Medicaid provides fertility preservation services as outlined in House Bill 283, *Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act)*.² The scope of coverage includes all procedures and medications that are “medically necessary” for fertility preservation and within the requirements as set forth in the § 15–810.1 of the Maryland Insurance Article.³

Pre-Authorization: Required. For specific CPT codes, please refer to the Maryland Medicaid FFS [Fee Schedule](#).

Covered services include:

- Fertility preservation consultation;
- Fertility preservation procedures including applicable laboratory assessments, medications and medically necessary treatments;
- Ovulation induction, monitoring, oocyte retrieval (For the purposes of oocyte retrieval only);
- Oocyte cryopreservation and evaluation;
- Ovarian tissue cryopreservation and evaluation;
- Sperm extraction, cryopreservation and evaluation;
- Gonadal suppression with GnRH analogs;
 - GnRH agonists may be offered to breast cancer patients to reduce the risk of premature ovarian insufficiency; and
 - Not be used in place of other fertility preservation alternatives.

Non-covered services include:

- Donor sperm;
- Donor oocytes;
- Fertility procedures. For example:
 - Intrauterine insemination procedures
 - In Vitro fertilization procedures
- Storage, and thawing of testicular tissue including associated charges;
- Prepubertal testicular tissue cryopreservation is considered investigational;
- Sperm and oocyte banking/storage; and
- Thawing of cryopreserved sperm or oocytes.

Gender Affirming Care - Provider Information

- Gender Affirming Care for Gender Diverse Patients: Program Requirements for Providers (Appendix A)
- Gender Affirming Treatment - Example Medical Necessity Provider Documentation (Appendix B)⁴
- Gender Affirming Care Procedures and Medication Codes (Appendix C)

² <https://mgaleg.maryland.gov/2023RS/bills/hb/hb0283E.pdf>

³ <https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gin§ion=15-810.1&enactments=false>

⁴ This document is meant to serve as an example. Providers are not required to use this document. The example is only meant to indicate all medical necessity considerations a provider should include in their documentation.

Gender Affirming Care (GAC) for Gender Diverse Patients

Program Requirements for Providers

When applicable, the following information must be documented in the Medical Record:

Informed Consent:

- Patients must demonstrate the capacity to make fully informed decisions and consent to treatment.
- When consent involves a minor, parental consent will be required, and the current Maryland Minor Consent Laws will define who can consent for what services and providers' obligations.⁵

Documentation of Medical Necessity for GAC

- **For Adults:** Documentation of the medical necessity for GAC can be made by either a Mental Healthcare Professional (MHP) or a Somatic Healthcare Professional (SHP)/Primary Care Provider (PCP), as defined in COMAR 10.67.05.05A(5), who has competencies in the assessment of transgender and gender diverse people is required to recommend gender affirming medical and surgical treatment.
- **For Adolescents:** Documentation of the medical necessity for GAC needs to be from a multidisciplinary team that includes both somatic and mental health professionals. Documentation will be accepted from either the SHP or MHP member of the team.
- Documentation should include:
 - That the patient has either gender dysphoria or gender incongruence.
 - That the patient's experience of gender incongruence is marked and sustained.
 - Provider attestation that they have tried to identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.
 - That the provider has assessed the capacity of the patient to consent for treatment prior to the initiation of treatment.
 - Adolescent persons must demonstrate the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
- Once the documentation of medical necessity has been met, no additional documentation is required as patients navigate the continuum of GAC services.
- **Providers who can render a medical necessity diagnosis for GAC Services:**
 - Somatic Healthcare Professionals (SHP) must meet all of the following criteria:
 - Must be a somatic health professional with one of the following degrees: MD, DO, PhD, NP, PA, or CNM.
 - Trained in gender-affirming treatment, and has knowledge about gender diverse identities and expressions.
 - Demonstrate continuing education in the field of gender-affirming healthcare.
 - Mental Health Professionals (MHP) must meet all of the following criteria
 - Must be a mental health professional with one of the following degrees: PhD, MD, DO, EdD, DSc, DSW, Ps.D, LCPC, or LCSW-C.
 - Trained in gender-affirming treatment and has knowledge about gender

⁵ Maryland Code, Health-General § 20-102, <https://health.maryland.gov/psych/pdfs/Treatment.pdf>.

- diverse identities and expressions.
 - Demonstrate continuing education in the field of gender affirmation and mental healthcare.
- Prior to rendering care, **providers who do not meet the criteria above** to appropriately assess and recommend patients for gender affirming care must obtain the documentation of a patient's medical necessity for GAC.

Required Documentation for Gender-Affirming Medical and Surgical Treatment

- **Gender-Affirming Medical Treatments:**
Includes: Puberty Suppression, Cross Sex Hormone Therapies, Voice Therapies, and Fertility Preservation
 - Documentation that the patient meets the medical necessity criteria for gender affirming care services.
 - Documentation or a letter of assessment (for those providers that do not meet the requirements to determine medical necessity outlined above) that the patient meets medical necessity for GAC.
 - The provider has assessed the capacity of the patient to consent for treatment prior to the initiation of treatment.
 - Providers for medical gender affirming therapy must meet the following criteria:
 - Must be a somatic health professional with one of the following degrees: MD, DO, PhD, NP, PA, CNM or are enrolled under the Atypical Provider Group - Electrologists and Tattoo Artists.
 - Have knowledge about gender diverse identities and expressions.
 - Adolescents must have reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
 - Provider attestation that they have assessed the capacity of the transgender, nonbinary, intersex, two-spirit, or other gender diverse individual to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.
- **Gender-Affirming Surgical Treatments:**
Gender-affirming surgeries require documentation of the following:
 - Documentation that the patient meets the medical necessity criteria for gender affirming care services.
 - Documentation or a letter of assessment (for those providers that do not meet the requirements to determine medical necessity outlined above) that the patient meets medical necessity for GAC.
 - The provider has assessed the capacity of the patient to consent for treatment prior to the initiation of treatment.
 - Provider attestation that they have tried to identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming surgeries.
 - Requirements for surgeons performing gonadal surgeries.
 - Training and documented supervision in gender-affirming procedures.

Appendix A

- Maintenance of an active practice in gender-affirming surgical procedures.
 - Knowledge about gender diverse identities and expressions.
 - Continuing education in the field of gender-affirmation surgery.
 - Tracking of surgical outcomes.
- Provider has assessed the capacity of the transgender, nonbinary, intersex, two-spirit, or other gender diverse adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming surgeries.
 - Adult transgender, nonbinary, intersex, two-spirit, and other gender diverse individuals seeking gender-affirming genital procedures, including gonadectomy, must have a minimum of 6 months of gender-affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy is either not clinically indicated; the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity; or the therapy is medically contraindicated).
 - Adolescents must have a minimum of 12 months of gender-affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy or gonadal suppression is either not clinically indicated; the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity; or the therapy is medically contraindicated).

Provider Documentation of Medical Necessity (Example Form)

- ☐ The patient is at least 18 years of age or has parental consent, and has demonstrated the capacity to make fully informed decisions and consent to treatment. When consent involves a minor, parental consent will be required, and the current Maryland Minor Consent Laws will define who can consent for what services and providers' obligations.⁶
- ☐ I am a Somatic Primary Care healthcare professional (Primary Care Provider as defined by COMAR 10.67.05.05A(5)) with a MD, PHD, DO, NP, PA, or CNM who has competencies in the assessment of transgender and gender diverse people seeking gender-related medical and surgical treatment, **OR**
- ☐ I am a mental health professional with a PhD, MD, EdD, DSc, DSW, PsyD, LCPC, or LCSW-C who has competencies in the assessment of transgender and gender diverse people seeking gender-related medical and surgical treatment.
- ☐ The patient has a diagnosis of **gender dysphoria** or **gender incongruence**.
 - The patient's experience of gender incongruence is marked and sustained.
 - The patient has the desire to make their body as congruent as possible with a desired gender through surgery, hormone treatment or other medical therapies.
 - The gender incongruence causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - The gender incongruence is not a symptom of another medical disorder.
- ☐ Prior to gender affirming **gonadal surgery**,
 - **Adults:** The patient must have experienced their desired gender for a minimum of 6 months of gender-affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy is either not clinically indicated; the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity; or the therapy is medically contraindicated).
 - **Adolescents:** The patient must have experienced their desired gender for a minimum of 12 months of gender-affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy or gonadal suppression is not clinically indicated, the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity or is medically contraindicated).
 - Start date of the patient experiencing their desired gender: ____/____/____
- ☐ The patient has no contraindicating somatic or mental health conditions that would impair their ability to participate in informed consent. In the situation where a patient has a mental health condition that interferes with their capacity to give informed consent and understand the risks, benefits, and alternatives to gender affirming treatment, the provider should facilitate treatment of the underlying condition to support the individual's ability to provide informed consent.
- ☐ The patient has the capacity to understand the effect of gender-affirming treatment on reproduction and has been versed in reproductive options prior to the initiation of gender-affirming surgeries that have the potential to create iatrogenic infertility.

⁶ Maryland Code, Health-General § 20-102, <https://health.maryland.gov/psych/pdfs/Treatment.pdf>.

Appendix B

- ☐ The patient has expressed full understanding of the psychological, social, and medical implications of treatment, for now and the future.

Signature

Date

Maryland Medicaid Program
Gender Affirming Care Procedures and Medication Codes

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Appendix C

NOTE: Codes shaded in red will be new additions to the Maryland Medicaid Fee-for-Service Fee Schedule, effective January 1, 2024. Rates for new additions are included in the below tables.

Table 1. Medical/Surgery Codes

CPT Code	Description	Rate
	Transition Surgeries	
19303	Mastectomy, Simple Complete	
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra	
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	
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	
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	
54660	Insertion of Testicular Prosthesis (Separate Procedure)	
55150	Resection of Scrotum	
55175	Scrotoplasty; Simple	
55180	Scrotoplasty; Complicated	
55980	Intersex Surgery; Female to Male	By Report
56620	Vulvectomy simple; partial	
56625	Vulvectomy Simple; Complete	
56630	Vulvectomy	
56633	Vulvectomy, Radical, Complete	
56640	Vulvectomy, Radical, Complete, W/Inguinofemoral, Iliac, & Pelvic Lymphadenectomy	
56700	Partial Hymenectomy/Revision, Hymenal Ring	

Appendix C

CPT Code	Description	Rate
57106	Vaginectomy, Partial Removal of Vainal Wall	
57107	Vaginectomy, Partial Removal Of Vaginal Wall; With Removal Of Paravaginal Tissue (Radical Vaginectomy)	
57109	Vaginectomy, Partial Removal, Vaginal Wall; W/Removal, Paravaginal Tissue (Radical Vaginectomy)	
57110	Vaginectomy, Complete Removal of Vaginal Wall	
57111	Vaginectomy, Complete Removal Of Vaginal Wall; With Removal Of Paravaginal Tissue (Radical Vaginectomy)	
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)	
57200	Colporrhaphy, suture of injury of vagina (nonobstetrical)	
58210	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without	
58260	Vaginal Hysterectomy, for Uterus 250G or Less	
58262	Vaginal Hysterectomy, for Uterus 250G of less; with removal of Tube(s), and/or Ovary(s)	
58263	Vaginal Hysterectomy, For Uterus 250 G Or Less; With Removal Of Tube(S), And/Or Ovary(S), With Repair Of Enterocele	
58267	Vaginal Hysterectomy, For Uterus 250 G Or Less; With Colpo-Urethrocystopexy (Marshall-Marchetti-Krantz Type, Pereyra Type) With Or Without Endoscopic Control	
58270	Vaginal Hysterectomy, For Uterus 250 G Or Less; With Repair Of Enterocele	
58275	Vaginal Hysterectomy, with Total or Partial Vaginectomy.	
58280	Vaginal hysterectomy	
58285	Vaginal Hysterectomy, Radical (Schauta Type Operation)	
58290	Vaginal Hysterectomy, For Uterus Greater than 250G	
58291	Vaginal Hysterectomy, for Uterus Greater than 250G; with removal of Tube(s) and/or Ovary(s)	
58292	Vaginal Hysterectomy, For Uterus Greater Than 250 G; With Removal Of Tube(S) And/Or Ovary(S), With Repair Of Enterocele	
58294	Vaginal Hysterectomy, For Uterus Greater Than 250 G; With Repair Of Enterocele	
58541	Laparoscopy, Surgical, Supracervical Hysterectomy for Uterus 250G or Less.	
58542	Laparoscopic Supracervical Hysterectomy (LSH). Laparoscopy, Surgical, Supracervical Hysterectomy for Uterus 250G or Less. Including tubes and ovaries	
58543	Laparoscopic Supracervical Hysterectomy (LSH). Laparoscopy, Surgical, Supracervical Hysterectomy for Uterus greater than 250G. Excludes tubes and ovaries.	
58544	Laparoscopic Supracervical Hysterectomy (LSH)Laparoscopy, Surgical, Supracervical Hysterectomy for Uterus greater than 250G. Including tubes	

Appendix C

CPT Code	Description	Rate
	and ovaries	
58570	Total Laparoscopic Hysterectomy (TLH) Laparoscopy, Surgical, Total Hysterectomy with Detachment of entire uterine cervix and body. via the laparoscope, for Uterus 250G or Less. Excludes tubes and ovaries.	
58571	Total Laparoscopic Hysterectomy (TLH) Laparoscopy, Surgical, Total Hysterectomy with Detachment of entire uterine cervix and body. via the laparoscope, for Uterus 250G or Less. Includes tubes and ovaries.	
58572	Total Laparoscopic Hysterectomy (TLH) Laparoscopy, Surgical, Total Hysterectomy with Detachment of entire uterine cervix and body. via the laparoscope, for Uterus greater than 250G. Excludes tubes and ovaries	
58573	Total Laparoscopic Hysterectomy (TLH) Laparoscopy, Surgical, Total Hysterectomy with Detachment of entire uterine cervix and body. via the laparoscope, for Uterus greater than 250G. Includes tubes and ovaries	
58550	Laparoscopic Assisted Vaginal Hysterectomy (LAVH). Detachment of the entire uterine cervix and body via the laparoscope and vagina. for Uterus 250G or Less. Excludes tubes and ovaries.	
58552	Laparoscopic Assisted Vaginal Hysterectomy (LAVH). Detachment of the entire uterine cervix and body via the laparoscope and vagina. for Uterus 250G or Less. Includes tubes and ovaries.	
58553	Laparoscopic Assisted Vaginal Hysterectomy (LAVH). Detachment of the entire uterine cervix and body via the laparoscope and vagina, for Uterus greater than 250G. Excludes tubes and ovaries.	
58554	Laparoscopic Assisted Vaginal Hysterectomy (LAVH). Detachment of the entire uterine cervix and body via the laparoscope and vagina, for Uterus greater than 250G. Includes tubes and ovaries.	
58720	Salpingo-oophorectomy, complete or partial, unilateral or Bilateral (separate procedure)	
58940	Oophorectomy, partial or total, unilateral or bilateral;	
58999	Unlisted procedure, female genital system (nonobstetrical)	
	Transition Surgeries	
19325	Breast Augmentation with Implant	
19328	Removal of intact breast implant	
54120	Amputation of penis; partial	
54125	Amputation of Penis; Complete	
54520	Orchiectomy, Simple (Including Subcapsular), with or without Testicular Prosthesis, Scrotal or Inguinal Approach	
54522	Orchiectomy, partial	
54690	Laparoscopy, Surgical; Orchiectomy	
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	
55866	Laparoscopy, Surgical Prostatectomy, Retropubic Radical Including Nerve Sparing, Includes Robotic Assistance, When Performed.	
55899	Unlisted procedure, male genital system	

Appendix C

CPT Code	Description	Rate
55970	Intersex Surgery; Male to Female	By Report
55980	Intersex Surgery; Female to Male	
56800	Plastic Repair of Introitus	
56805	Clitoroplasty for Intersex State	
56810	Perineoplasty, repair of Perineum, non obstetrical	
57282	Colpopexy, vaginal, extra-peritoneal approach	
57291	Construction of Artificial Vagina, without Graft	
57292	Construction of Artificial Vagina, with Graft	
57335	Vaginoplasty for Intersex State	
57425	Laparoscopy, surgical colpopexy	
	Procedures to the Face and Neck	
15819	Cervicoplasty	
15820	Blepharoplasty, Lower Eyelid	
15821	Blepharoplasty, Lower Eyelid; with Extensive Herniated Fat Pad	
15822	Blepharoplasty, Upper Eyelid	
15823	Blepharoplasty, Upper Eyelid; with Excessive Skin Weighting Down Lid	
15824	Rhytidectomy; Forehead	
15825	Rhytidectomy; Neck with Platysmal Tightening (Platysma Flap, P-Flap)	
15826	Rhytidectomy; Glabellar Frown Lines	
15828	Rhytidectomy; Cheek, Chin, and Neck	
15829	Rhytidectomy; Superficial Musculoaponeurotic System (SMAS) Flap	
15860	Under Other Repair (Closure) Procedures on the Integumentary System	
21120	Genioplasty; Augmentation (Autograft, Allograft, Prosthetic Material)	
21121	Genioplasty; Sliding Osteotomy, Single Piece	
21122	Genioplasty; Sliding Osteotomies, 2 or more Osteotomies (EG, Wedge Excision or Bone Wedge Reversal for Asymmetrical Chin)	
21137	Forehead Contouring	
21138	Forehead Contouring	
21139	Forehead Contouring	
21270	Cheek Augmentation	
21123	Genioplasty; Sliding, Augmentation with Interpositional Bone Grafts (including 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)	
21141	Reconstruction Midface, Lefort I; 1 Piece, W/O Bone Graft	

Appendix C

CPT Code	Description	Rate
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	
21145	Reconstruction Midface, Lefort I; 1 Piece, W/Bone Grafts	
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining	
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes o	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	
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)	
21215	Graft, Bone; Mandible (Includes Obtaining Graft)	
21230	Graft; Rib Cartilage, Autogenous, To Face, Chin, Nose Or Ear (Includes Obtaining Graft)	
21235	Graft; Ear Cartilage, Autogenous, To Nose Or Ear (Includes Obtaining Graft)	
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	
21295	Reduction, Masseter Muscle/Bone; Extraoral Approach	
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach	
21299	Unlisted craniofacial and maxillofacial procedure	
21087	Impression And Custom Preparation; Nasal Prosthesis	
21172	Reconstruct orbit/forehead	
21175	Repair, Revision, and/or Reconstruction Procedures on the Head	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	
21193, 21194, 21195, 21196	Reconstruction of Mandibular rami	
21198	Osteotomy, Mandible, Segmental	
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	

Appendix C

CPT Code	Description	Rate
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)	
30460	Revision of Nose	
31599	Unlisted procedure, larynx [thyroid chondroplasty and tracheal shave] [voice modification surgery]	By Report
31750	Tracheoplasty	
31899	Trachea shave/reduction thyroid chondroplasty (thyroid cartilage reduction)	By Report
40500	Excision Procedures on the Lips	
40510	Excision Of Lip; Transverse Wedge Excision With Primary Closure	
40520	Excision Of Lip; V-Excision With Primary Direct Linear Closure	
40525	Excision Of Lip; Full Thickness, Reconstruction With Local Flap (E.G., Estlander Or Fan)	
40527	Excision Of Lip; Full Thickness, Reconstruction With Cross Lip Flap (Abbe-Estlander)	
40650	Repair of lip and border	
40652	Repair Procedures on the Lips	
40654	Repair of vertical lip wound extending to over half of lip	
40799	Unlisted procedure, lips	
67900	Brow Lift Blepharoplasty (in conjunction with other facial feminization procedures)	
67901	Brow Lift Blepharoplasty (in conjunction with other facial feminization procedures)	
67902	Brow Lift Blepharoplasty (in conjunction with other facial feminization procedures)	
69300	Otoplasty	
	Procedures Related to the Skin, Abdomen, Chest, Truck, and Buttocks	
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	
	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional	

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CPT Code	Description	Rate
11922	20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	
20926	Gluteal augmentation - Brazilian Butt Lift (BBL)	\$300
11950	Injection of filling material (collagen); 1 cc or less	
11951	Injection of filling material (collagen); 1.1 to 5 cc	
11952	Injection of filling material (collagen); 5.1 to 10 cc	
11954	Injection of filling material (collagen); over 10 cc	
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	
11970	Replacement of tissue expander with permanent implant	
11971	Removal of tissue expander without insertion of implant	
11981	Insertion, Non-Biodegradable Drug Delivery Implant	
11982	Removal, Non-Biodegradable Drug Delivery Implant	
11983	Removal W/Reinsertion, Non-Biodegradable Drug Delivery Implant	
13132	Repair of wound (2.6 to 7.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet	
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	
13152	Repair of wound (2.6 to 7.5 centimeters) of eyelids, nose, ears, and/or lips	
13153	Repair of wound of eyelids, nose, ears, and/or lips	
13160	Second repair of complex surgical wound	
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	
14021	Tissue transfer repair of wound (10.1 to 30.0 sq centimeters) of the scalp, arms, and/or legs	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	
14302	14301 and each additional 30.0 square centimeters or part thereof	
15100	Skin graft at trunk, arms, or legs (first 100 sq cm or less, or 1% body are of infants and children)	
15101	Split-Thickness Autograft, Trunk, Arms, Legs; Each Additional 100 Sq Cm, Or Each Additional 1% Of Body Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	
15120	Skin graft of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 100 sq cm or less, or 1% body area of infants and children)	
15121	Split-Thickness Autograft, Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, And/Or Multiple Digits; Each Additional 100 Sq Cm,	

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CPT Code	Description	Rate
	Or Each Additional 1% Of Body Area Of Infants And Children, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	
15200	Full thickness graft, free, including direct closure of donor site, trunk	
15201	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	
15273	Application of skin substitute (wound surface greater or equal to 100 sq cm) to trunk, arms, or legs (first 100 sq cm or 1% body area of infants and children)	
15274	Application of skin substitute (wound surface greater or equal to 100 sq cm) to trunk, arms, or legs	
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	
15241	15240 - each additional 20 sq.cm. or less.	
15570	Formation Of Direct Or Tubed Pedicle, With Or Without Transfer; Trunk	
15574	Formation Of Direct Or Tubed Pedicle, With Or Without Transfer; Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands Or Feet	
15600	Delay Of Flap Or Sectioning Of Flap (Division And Inset); At Trunk	
15620	Delay Of Flap Or Sectioning Of Flap (Division And Inset); At Forehead, Cheeks, Chin, Neck, Axillae, Genitalia, Hands, Or Feet	
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	
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	
15769	Grafting of Autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	
15771, 15774	Grafting of autologous fat harvested by liposuction technique to various locations	
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	
15780	Dermabrasion total face	
15781	Dermabrasion segmental face	
15782	Dermabrasion other than face	
15786	Abrasion; single lesion (e.g., keratosis, scar)	
15787	Abrasion; each additional 4 lesions or less (List separately in addition to	

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CPT Code	Description	Rate
	code for primary procedure)	
15788	Chemical Peel: Facial; Epidermal	
15789	Chemical Peel; Dermal	
15792	Chemical Peel; Nonfacial: Epidermal	
15793	Chemical Peel; Nonfacial; Dermal	
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 Monsplasty/mons reduction.	
15847	Excision, Excessive Skin And Subcutaneous Tissue (Includes Lipectomy), Abdomen (Eg, Abdominoplasty) (Includes Umbilical Transposition And Fascial Plication) (List Separately In Addition To Code For Primary Procedure)	
17110	Destruction (Eg, Laser Surgery, Electrosurgery, Cryosurgery, Chemosurgery, Surgical Curettement), Of Benign Lesions Other Than Skin Tags Or Cutaneous Vascular Proliferative Lesions; Up To 14 Lesions	
17111	Destruction (Eg, Laser Surgery, Electrosurgery, Cryosurgery, Chemosurgery, Surgical Curettement), Of Benign Lesions Other Than Skin Tags Or Cutaneous Vascular Proliferative Lesions; 15 Or More Lesions	
15775	Punch graft hair transplant	\$183 (Fac), \$263 (non Fac)
15776	Punch graft hair transplant	\$251 (Fac), \$356 (non Fac)
17380	Electrolysis Epilation, Each 30 Minutes	\$90
15876	Suction Assisted Lipectomy; Head and Neck	\$1,100
15877	Suction Assisted Lipectomy; Trunk	\$1,100
15878	Suction Assisted Lipectomy; Upper Extremity	\$1,100
15879	Suction Assisted Lipectomy; Lower Extremity	\$1,100
17999	Other Procedures on the Integumentary System (laser hair removal)	\$1,000

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CPT Code	Description	Rate
19316	Mastopexy	
19318	Breast reduction	
19340	Insertion of Breast Prosthesis; Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	
19342	Insertion of Breast Prosthesis; Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	
19350	Nipple/Areola Reconstruction	
19355	Correction Of Inverted Nipples	
19357	Tissue Expander Placement In Breast Reconstruction, Including Subsequent Expansion(S)	
19361	Breast Reconstruction; With Latissimus Dorsi Flap	
19364	Breast Reconstruction; With Free Flap (Eg, Ftram, Diep, Siea, Gap Flap)	
19367	Breast Reconstruction; With Single-Pedicled Transverse Rectus Abdominis Myocutaneous (Tram) Flap	
19368	Breast Reconstruction; With Single-Pedicled Transverse Rectus Abdominis Myocutaneous (Tram) Flap, Requiring Separate Microvascular Anastomosis (Supercharging)	
19369	Breast Reconstruction; With Bipedicled Transverse Rectus Abdominis Myocutaneous (Tram) Flap	
19370	Revision Of Peri-Implant Capsule, Breast, Including Capsulotomy, Capsulorrhaphy, And/Or Partial Capsulectomy	
19371	Peri-Implant Capsulectomy, Breast, Complete, Including Removal Of All Intracapsular Contents	
19380	Revision Of Reconstructed Breast (Eg, Significant Removal Of Tissue, Re-Advancement And/Or Re-Inset Of Flaps In Autologous Reconstruction Or Significant Capsular Revision Combined With Soft Tissue Excision In Implant-Based Reconstruction)	
19396	Preparation Of Moulage For Custom Breast Implant	
27656	Calf Implant	
53210	Urethrectomy, total, including cystostomy; female	
64856	Suture Of Major Peripheral Nerve, Arm Or Leg, Except Sciatic; Including Transposition	
64892	Nerve Graft (Includes Obtaining Graft), Single Strand, Arm Or Leg; Up To 4 Cm Length	
64896	Nerve Graft (Includes Obtaining Graft), Multiple Strands (Cable), Hand Or Foot; More Than 4 Cm Length	
64912	Neurorrhaphy With Nerve Graft, Vein Graft or Conduit Procedures	
45395	Under Excisional Laparoscopic Procedures on the Rectum	
43496	Under Other Procedures on the Esophagus	
44204	Laparoscopic Excision Procedures on the Intestines (Except Rectum)	
44700	Other Procedures on the Intestines (Except Rectum)	
45400	Laparoscopic Repair Procedures on the Rectum	

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CPT Code	Description	Rate
	Alterations to Voice, Voice Therapy, and Voice Lessons	
21899	Cricothyroid approximation voice modification that raises the vocal pitch by simulating contractions of the cricothyroid muscle with sutures	By Report
31081	Under Other Procedures on the Larynx Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)	
31580	Laryngoplasty, reshaping of laryngeal framework (voice modification surgery) Surgical procedure in which the provider repairs or alters the larynx (voice box) or its structures.	
31599	Under Other Procedures on the Larynx Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder.	
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	
92524	Behavioral and qualitative analysis of voice and resonance.	
31599	Other Procedures on the Larynx	
	Revision and Reversal Procedures	
57295	Revision (Including Removal) Of Prosthetic Vaginal Graft; Vaginal Approach	
57296	Revision (Including Removal) Of Prosthetic Vaginal Graft; Open Abdominal Approach	
57426	Revision (Including Removal) Of Prosthetic Vaginal Graft, Laparoscopic Approach	

Appendix C

Table 2. Laboratory Services Codes

CPT Code	Description	Rate
80414	Testosterone response panel	
80415	Total estradiol response panel	
82642	Dihydrotestosterone	
82670	Assay of total estradiol	
82671	Assay of estrogens	
82672	Assay of estrogen	
82677	Assay of estriol	
82679	Assay of estrone	
82681	Assay direct measure free estradiol	
83001	Assay of gonadotropin (fsh)	
83002	Assay of gonadotropin (lh)	
83003	Assay growth hormone (hgh)	
83498	Assay of hydroxyprogesterone 17-d	
84143	Assay of 17-hydroxypregnenolone	
84144	Assay of progesterone	
84233	Assay of estrogen	
84234	Assay of progesterone	
84402	Assay of free testosterone	
84403	Assay of total testosterone	
84410	Testosterone bioavailable	

Appendix C

Table 3. Hormone Therapy Codes

Under federal and state law, only medications approved by the Food and Drug Administration (FDA) and are subject to the Federal Rebate Program are considered for Medicaid coverage. All medications are subject to restrictions outlined in COMAR 10.09.03.05 and COMAR 10.67.06.04. Please note that oral, transdermal, and topical medications may not have an associated CPT code.

CPT Code	Description	Rate
11980	Subcutaneous hormone pellet implantation	
	Androgens	
	Testosterone Transdermal Patch	
	Testosterone Topical Gel	
J3121	Testosterone Enanthate Injection	
J1071	Testosterone Cypionate (Depo-Testosterone)	
S0189	Testosterone Pellet For Implant (Testopel)	
	Testosterone Undecanoate Cap (Jatenzo)	
J3145	Testosterone Undecanoate Inj	
	Estrogens	
	Alora (estradiol transdermal patch)	
J1380	Delestrogen (estradiol valerate)	
J1000	Depo-Estradiol(estradiol cypionate)	
	Estradiol oral tablet and sublingual	
	Estradiol oral tablet and sublingual	
	Minivelle (estradiol transdermal patch)	
	Vivelle (estradiol transdermal patch)	
	Climara (estradiol transdermal patch)	
	Vivelle-Dot (estradiol transdermal patch)	
	Gonadotropins	
J1950	Lupron Depot-Ped (leuprolide)	
J1951	Fensolvi (leuprolide)	
J1952	Leuprolide injectable, camcevi, 1 mg	
J9217	Eligard (Leuprolide Acetate)	
J9218	Leuprolide acetate, per 1 mg	
J9202	Zoladex (Goserelin Acetate)	
J9226	Supprelin LA (histrelin acetate implant)	
J3315	Injection, triptorelin pamoate, 3.75 mg	
J3316	Injection, triptorelin, extended-release, 3.75 mg	

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CPT Code	Description	Rate
	5-Alpha Reductase Inhibitor	
	Dutasteride	
	Propecia tablets (finasteride)	
	Proscar tablets (finasteride)	
	Aldosterone Receptor Antagonist	
	Aldactone (spironolactone)	
	Progestins	
J1050	Depo-Provera (medroxyprogesterone acetate),	
	Micronized Progesterone	
	Provera tablets (medroxyprogesterone acetate)	

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Table 4. Puberty Suppression Medications

CPT Code	Description	Rate
J1950	Injection, Leuprolide Acetate (For Depot Suspension), Per 3.75mg	
J1951	Fensolvi (leuprolide)	
J1952	Leuprolide Injectable, Camcevi, 1 Mg	
J3315	Injection, Triptorelin Pamoate, 3.75 Mg	
J3316	Injection, Triptorelin, Extended-Release, 3.75 Mg	
J9202	Goserelin Acetate Implant, Per 3.6 Mg (Zoladex)	
J9217	Leuprolide Acetate (For Depot Suspension), 7.5 Mg (Eligard)	
J9218	Leuprolide Acetate, Per 1 Mg	
J9219	Leuprolide Acetate Implant, 65 Mg (Supprelin La)	

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Table 5. Fertility Preservation Codes

CPT Code	Description	Rate
	Procedures	
58825	Transposition of the ovary(s). This procedure protects the ovaries before the patient receives pelvic radiation to treat cancer.	
55870	Electroejaculation	By Report
58970	Follicle puncture for oocyte retrieval, any method	By Report
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	\$56.77
89254	Oocyte identification from follicular fluid	\$424
89257	Sperm identification from aspiration (other than seminal fluid)	\$315.58
89259	Cryopreservation; sperm	\$270
89264	Sperm identification from testis tissue, fresh or cryopreserved	\$424
89337	Cryopreservation, mature oocyte(s)	\$1,000
89398	Unlisted reproductive medicine laboratory procedure, cryopreservation of reproductive tissue, ovarian	\$315.58
S4028	Microsurgical epididymal sperm aspiration (MESA)	By Report
S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, non face- to- face medical management of the patient), per cycle	By Report
	Medications	
J0725	Chorionic gonadotropin, per 1,000 USP units	\$22.63
J3355	Injection, urofollitropin, 75 IU Injection	\$125
S0122	Injection, menotropins, 75 IU	\$225
S0126	Injection, follitropin alfa, 75 IU	\$241
S0128	Injection, follitropin beta, 75 IU	\$184
S0132	Injection, ganirelix acetate, 250 mcg	\$184