Gender Affirming Care Services

Page updated: November 2025

This section contains coverage and policy information for Medi-Cal members who receive medically necessary services that do not match their gender assigned at birth. This may also differ from the gender identified on their Medi-Cal enrollment records.

Gender Affirming Care Services

In all sections of the Medi-Cal and specialty programs provider manuals, regardless of the gender stated, the gender affirming care benefits and policy in this section apply to Medi-Cal members of all gender identities so long as the procedure/benefit is medically necessary and meets all other Medi-Cal coverage and policy requirements.

Overriding Gender Differences

When the gender on the claim conflicts with the billed procedure code due to a variation of sexual development or gender dysphoria, the gender difference is overridden by either:

- Attaching an approved *Treatment Authorization Request* (TAR) or Service Authorization Request (SAR).
- Adding modifier KX (requirements specified in the medical policy have been met) to the billed procedure code.

Note: The Medi-Cal member's medical record must support the medical necessity for the procedure, due to a medical condition identified with a clinically appropriate International Classification of Diseases, Tenth Revision (ICD-10) code (or multiple codes) that led to the gender difference.

The claim does not require documentation, but the provider must maintain appropriate documentation in the Medi-Cal member's medical record, as described below in this section.

Note: Use of KX modifier does not override other policy requirements for an approved TAR or SAR.

Covered Benefits

Gender affirming care is a covered Medi-Cal benefit when medically necessary. Gender affirming care refers to services provided to address incongruence between a Medi-Cal member's gender assigned at birth and their gender identity. Services should be rendered by providers specially trained and experienced in providing culturally competent gender affirming care services.

Providers should refer to nationally recognized clinical practice guidelines emphasizing evidence-based medicine, general clinical consensus, and alignment with the current standard of care for gender affirming care services, including but not limited to, publications from the following:

- World Professional Association for Transgender Health
- Endocrine Society
- American Academy of Pediatrics (for Medi-Cal members up to age 21)
- American Psychological Association

Note: This is not an exhaustive list of clinical practice guidelines or professional resources in this space.

Medi-Cal gender affirming care services must be provided timely and include the following core services:

- Pharmacy services, including prescription, hormone and puberty-blocking medications.
- Medical services, including mental and behavioral health services as well as a variety of surgical procedures and other treatments, including ancillary services incident to those services.

Medical Necessity

Medically necessary services are those services that “are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury” (*California Code of Regulations* [CCR], Title 22, Section 51303; see also *Welfare and Institutions Code* section 14059.5) and Title XIX of the Social Security Act, Section 1905(r)(5);Title 42 of the United States Code section 1396d(r)(5)).). For Medi-Cal members under 21 years of age, a service is "medically necessary" or a "medical necessity" pursuant to the longstanding, federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. For more information, please refer to the EPSDT (epsdt) section of the Medi-Cal Provider Manual. Providers must assess medical necessity for each individual Medi-Cal member.

Note: In the case of gender affirming care services, “normal appearance” is determined by referencing the gender with which the Medi-Cal member identifies. Reconstructive surgery to create a normal appearance for Medi-Cal members is determined to be medically necessary for the treatment of gender dysphoria on a case-by-case basis.

Service Limitations

Gender affirming care services are subject to all Medi-Cal coverage and policy requirements, including appropriate, non-discriminatory utilization management controls such as frequency limits, which in most cases may be overridden by a TAR/SAR for medical necessity.

A TAR or SAR is necessary only for procedures that currently require a TAR or SAR. The TAR or SAR must establish the medical necessity for the procedure as outlined in this section and any other applicable Medi-Cal coverage policies.

Note: Intersex surgery should not be requested or billed using CPT® code 55970 (intersex surgery; male to female) or CPT code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT coding should be specific for the procedures performed.

Non-Benefits Coverable with a TAR or SAR Override

For benefits or services corresponding to CPT or HCPCS codes that are listed in the *TAR and Non-Benefit: Introduction to List* section and subsequent numbered sections of the provider manual, providers may submit a TAR or SAR demonstrating medical necessity to obtain approval for coverage and reimbursement for an individual Medi-Cal member under this section.

Documentation Requirements

Providers rendering gender affirming care services to Medi-Cal members are expected to maintain documentation in the Medi-Cal member's medical record in accordance with applicable state and federal medical record retention requirements, which should include, but not be limited to, the following:

- Written provider orders and referrals to support the gender affirming care service(s), including a signature, if required by state or federal law.
- Informed Medi-Cal member consent and any other legally required consent/privacy documentation.
- A clear and accurate description of medical necessity, consistent with the applicable state and federal requirements, which includes a:
  - Medical history,
  - Clinically appropriate diagnosis (or multiple diagnoses) using an ICD-10 code(s),
  - Brief narrative explanation how the service is expected to improve, maintain, or address the Medi-Cal member's diagnosed condition(s), and
  - Whenever possible, it is preferrable to note why the service/benefit is the most clinically appropriate and cost-effective option to meet the Medi-Cal member's needs.
- Chart notes, which can include "to" and "from" dates for services, Medi-Cal member response to services, progress towards established goals, changes in Medi-Cal member's condition or circumstances, etc.
- Treatment plan or plan of care, which outlines goals, frequency, duration, and expected outcomes of services, as well as documentation of review and any adjustments made over time.
- Any TARs or SARs and all supporting documentation submitted with those requests.

Provider Requirements

Providers rendering gender affirming care services to Medi-Cal members must comply with all applicable state and federal statutes and regulations, as well as Medi-Cal policies, such as those related to confidentiality, consistent with the *Provider Regulations* section of the Medi-Cal Provider Manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.