



# Medical Policy

**Policy:** 201609

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

**SUBJECT:** Gender Dysphoria Treatment

**Annual Review Date:** 12/13/2017

**Last Revised Date:** 03/16/2018

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

**Definition:** Gender dysphoria<sup>†</sup> is the discomfort or distress that is caused by a discrepancy between an individual's gender identity and that individual's sex assigned at birth. Medical treatment includes feminization (male-to-female or MtF) or masculinization (female-to-male or FtM) of the body through hormone therapy and/or surgery, and psychotherapy including counseling and support. Gender reassignment surgery (transsexual surgery or sex reassignment surgery) refers to surgical procedures for the treatment of gender dysphoria. Surgery may include several staged procedures.

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

For breast surgery:

- A written assessment from at least one qualified behavioral health professional that documents that the individual meets **all** of the following:
  - $\geq$  18 years old; and
  - Capacity to make a fully informed decision and to consent for treatment that may be irreversible; and
  - Documented history of persistent gender dysphoria for at least 24 months; and
  - Absence of poorly controlled or unstable psychiatric condition.

For genital surgery:

- A written assessment from at least two qualified behavioral health professionals that documents that the individual meets all of the following:
  - $\geq$  18 years old; and
  - Capacity to make a fully informed decision and to consent for treatment that may be irreversible; and
  - Documented history of persistent gender dysphoria for at least 24 months; and

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- Absence of poorly controlled or unstable psychiatric condition; and
- Completed hormone therapy of at least 12 continuous months for feminization or masculinization unless medically contraindicated; and
- Documented history of preoperative, 12 continuous months of living in a gender role that is congruent with gender identity.

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

- Male-to-female (MtF): penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty.
- Female-to-male (FtM): bilateral mastectomy or breast reduction, hysterectomy, salpingo-oophorectomy; urethroplasty, metoidioplasty, phalloplasty, vulvectomy, vaginectomy, scrotoplasty and implantation of penile and/or testicular prostheses.

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

- Abdominoplasty
- Blepharoplasty
- Botulinum toxin
- Breast augmentation including implants
- Brow lift
- Calf implants
- Collagen injections
- Dermal filler injections
- Facial implants
- Facial modifications including facial feminization and face lift
- Gluteal augmentation including implants/lipofilling
- Hair reconstruction including permanent hair removal or hair transplant
- Laryngoplasty
- Lipofilling/collagen injections
- Liposuction or lipoplasty
- Lip reduction/enhancement
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing
- Thyroid chondroplasty (reduction of the Adam's apple)

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- Other aesthetic or cosmetic procedures not listed

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

- Reproduction services (cryopreservation, storage and thawing of reproductive tissue)
- Speech therapy for vocal training
- Vocal cord procedures (voice modification surgery)

## NOTES:

- Reversal of gender reassignment surgery is not eligible for reimbursement.
- Hormone therapy is subject to the individual's prescription drug benefit plan.
- Current certificate books exclude coverage for surgical and non-surgical management of gender dysphoria. To verify coverage refer to member mailings and updated certificate books as they become available.

## † Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Criteria for Gender Dysphoria:

### Gender dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (on in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (on in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and /or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

*Specify if:*

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

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

*Specify if:*



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

† † **Written documentation includes a letter of referral conforming to the World Professional Association for Transgender Health (WPATH) guidelines and should cover six key elements:**

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

### **Documentation Requirements:**

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



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## Sources of Information:

- American College of Obstetricians and Gynecologists (ACOG). (2011, December). The American College of Obstetricians and Gynecologists. Committee Opinion. Committee on Health Care for Underserved Women. Health Care for Transgender Individuals. Retrieved from <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co512.pdf?dmc=1&ts=20171024T1511567520>
- American College of Obstetricians and Gynecologists (ACOG). (2017, January). The American College of Obstetricians and Gynecologists. Committee Opinion. Committee on Adolescent Health Care. Care for Transgender Adolescents. Retrieved from <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Care-for-Transgender-Adolescents>
- Coleman E., Adler R., Bocking W, et al. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Version 7. Minneapolis, MN: World Professional Association for Transgender Health (WPATH); 2011. [http://www.wpath.org/publications\\_standards.cfm](http://www.wpath.org/publications_standards.cfm). Accessed October 23, 2017.
- Hayes, Inc., Lansdale, PA: Author.
  - *Ancillary Procedures and Services for the Treatment of Gender Dysphoria*. (2014, May 09). Annual Review (2017, April 17).
  - *Hormone Therapy for the Treatment of Gender Dysphoria*. (2014, May 09). Annual Review (2017, April 18)
  - *Sex Reassignment Surgery for the Treatment of Gender Dysphoria*. (2014, May 15). Annual Review (2017, April 18).
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 451-459.

<b>Applicable Code(s):</b>	
<b>CPT:</b>	19303, 19304, 53430, 54125, 54400, 54401, 54405, 54520, 54660, 54690, 55180, 55970, 55980, 56625, 56800, 56805, 57110, 57291, 57292, 57335, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661
<b>ICD10 Procedure Codes:</b>	0UQG0ZZ, 0UQJ0ZZ-0UQJXZZ, 0UT20ZZ-0UT2FZZ, 0UT70ZZ-0UT7FZ, 0UT90ZZ-0UT9FZZ, 0UTC0ZZ-0UTC8ZZ, 0UTG0ZZ-0UTG8ZZ, 0UTJ0ZZ-0UTJXZZ, 0UTM0ZZ-0UTMXZZ, 0VRC0JZ, 0VTC0ZZ-0VTC4ZZ, 0VTS0ZZ-0VTSXZZ, 0VUS07Z-0VUSX7Z, 0VUS0JZ-0VUSXJZ, 0VUS0KZ-0VUSXKZ, 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0, 0W4N071, 0W4N0J1, 0W4N0K1, 0W4N0Z1
<b>ICD-10 Diagnosis Codes:</b>	F64.0, F64.1, F64.2, F64.8, F64.9

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