Gender Identity Services

I. Policy

University Health Alliance (UHA) will cover Gender Identity Services when such services meet the medical criteria guidelines (subject to limitations and exclusions) indicated below. UHA does not deny, exclude, or limit health care services or treatment to a member on the basis of the member's actual identity or perceived gender identity.

II. Background

Gender dysphoria is defined by strong, persistent feelings of dissonance between one's gender identity and biological gender, accompanied by clinically significant distress or impairment in social or occupational arenas. Individuals diagnosed with gender dysphoria should first receive psychotherapy from a mental health professional before receiving any medical treatment. Psychiatric diagnoses must be analytic and evidence-based.

Those who seek to halt puberty and/or to cause their bodies to minimize or develop masculine or feminine secondary sex characteristics may choose to receive hormone therapy depending on their specific gender identity. Hormone therapy is usually considered medically necessary when supported by evidence-based documentation and when it meets the criteria and guidelines below.

Some individuals choose to surgically alter their bodies to align with their gender identities. Certain procedures involved in genital reassignment surgery are reconstructive in nature and are deemed medically necessary when supported by documentation from preceding transitional treatment stages. However, many other surgical procedures that change a person's physical appearance are generally considered cosmetic and their benefit as a treatment for gender dysphoria is not clear. These procedures must be reviewed on a case-by-case basis for medical necessity.

In accord with Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), this Medical Policy provides coverage of services that are medically necessary for the treatment of gender dysphoria. The application of the Criteria/Guidelines (Section III) and Limitations (Section IV) set forth in this Medical Policy will take into account the characteristics of the individual patient in determining the medical necessity of the services requested.

This policy is not intended to address the treatment of infants and children with ambiguous genitalia.

III. Criteria/Guidelines

A. Psychotherapy and/or sexual identification counseling for treatment of gender dysphoria are covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:

   1. Services are provided by a qualified mental health professional (see Appendix A for required characteristics);
   2. The patient undergoes an initial assessment of gender identity and dysphoria, the historical development of gender dysphoric feelings, and severity of resulting stress caused by the condition; and
   3. The mental health professional documents goals to assess, diagnose, and discuss treatment options (if needed) for gender dysphoria and any coexisting mental health concerns prior to initiation of hormone therapy or surgical procedures (if applicable).

B. Puberty suppression therapy is covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:

1. The patient has been diagnosed with persistent, well-documented gender dysphoria as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria (see Appendix B) and gender identity disorder as defined by the current International Classification of Diseases (ICD) criteria by a qualified mental health professional (see Appendix A);
2. The patient has exhibited the first physical changes of puberty, indicated by a minimum Tanner stage of 2 or 3;
3. The patient has completed at least three months of successful continuous full time real-life experience in their gender identity across a wide span of life experiences and events (e.g., holidays, vacations, season-specific school and/or work experience, family events);
4. Clinical records document that the patient assents to treatment and the parent/guardian has made a fully informed decision and consents to treatment;
5. The patient's comorbid medical and mental health conditions (if present) are reasonably well-controlled; and
6. Puberty suppression therapy will be administered in a safe, appropriate, medically supervised manner.

C. Continuous hormone replacement therapy is covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:
    1. The patient is at least 16 years of age;
    2. The patient has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (see Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified mental health professional (see Appendix A);
    3. The patient has completed at least three months of successful continuous full time real-life experience in their gender identity across a wide span of life experiences and events (e.g., holidays, vacations, season-specific school and/or work experience, family events);
    4. Clinical records document that the patient has made a fully informed decision and (if at least age 18) consents to treatment or (if under age 18) assents to treatment and a parent/guardian consents to treatment;
    5. The patient's comorbid medical and mental health conditions (if present) are reasonably well-controlled; and
    6. Continuous hormone replacement therapy will be administered in a safe, appropriate, medically supervised manner

D. Mastectomy is covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:
    1. The patient is at least 18 years of age;
    2. The patient has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (see Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified mental health professional (see Appendix A);
    3. Clinical records document that the patient has made a fully informed decision and consents to treatment;
    4. The patient's comorbid medical and mental health conditions (if present) are reasonably well-controlled; and
    5. The patient has obtained a referral letter from a qualified mental health professional (see Appendix A).

E. Fertility counseling is covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:

1. Fertility counseling is provided by a qualified health care professional;
2. The service is provided prior to removal of testes or ovaries; and
3. The counselor documents that the patient has been advised about contraceptive use, effects of transition on fertility, and options for fertility preservation and reproduction.

F. Genital reassignment surgery is covered (subject to Limitations and Administrative Guidelines) when all of the following criteria are met:

1. The patient is at least 18 years of age;
2. The patient has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (see Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified mental health professional (see Appendix A)
3. The patient has completed a minimum of 12 months of continuous hormonal therapy (unless contraindicated) when recommended by a mental health professional and provided under the supervision of a physician.
4. The patient has completed a minimum of 12 months of successful continuous full time real-life experience in their gender identity, across a wide span of life experiences and events that occur throughout the year (i.e., holidays, vacations, season-specific school and/or work experience, family events);

   Note: The patient may complete 12 months of continuous hormone therapy and 12 months of real-life experience in their gender identity concurrently.
5. Clinical records document that the patient made a fully informed decision and consents to treatment;
6. The patient's comorbid medical and mental health conditions (if present) are reasonably well-controlled; and
7. The patient has obtained referral letters from two qualified health care professionals. One of the professionals must be the patient's psychotherapist and the other must be the physician supervising the patient's continuous hormone replacement therapy.

G. Preventive Services

1. Cancer screening services are covered (subject to Limitations and Administrative Guidelines) for patients who retain a particular body part or organ (e.g., breasts, prostate, cervix) and otherwise meet criteria for screening based on risk factors or symptoms, regardless of hormone use. Please see the relevant UHA policy for coverage criteria.
2. Screening for breast cancer may be covered (subject to Limitations and Administrative Guidelines) for patients who have used or are currently using feminizing hormones and will be considered on a case-by-case basis.
3. In patients who have had a neocervix created from the glans penis, routine cytological examination of the neocervix may be covered (subject to Limitations and Administrative Guidelines) and will be considered on a case-by-case basis.

IV. Limitations and Exclusions

A. The following services are considered cosmetic and do not meet criteria for medical necessity: Coverage exceptions can be requested for review on an individual basis.

1. Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction,

feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic.

2. Chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.
3. Procedures performed to exaggerate masculine or feminine traits beyond the range of norms found within society are not covered.
4. Rejuvenation treatments are not covered.
5. Procedures that primarily serve to beautify or otherwise enhance one's physical appearance are considered cosmetic and are not covered.

B. Gender identity services provided outside of Hawaii are not covered unless cleared by UHA prior to any out of state services. See UHA's Out of State Services policy for details.

C. Services performed outside of the United States are not covered benefits. Coverage exceptions can be requested for review on an individual basis.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

V. Administrative Guidelines

A. Prior authorization is not required for psychotherapy, sexual identity counseling, or fertility counseling for treatment of gender dysphoria. UHA reserves the right to perform retrospective reviews using the above criteria to validate whether services rendered met payment determination criteria. Please maintain relevant documentation for gender identity services received as they may be necessary for the patient to qualify for coverage for additional transition-related interventions.

B. Prior authorization is required through the UHA pharmacy benefit manager (PBM) for many of the pharmacologic/hormone interventions that relate to this policy. Please review relevant criteria in the applicable PBM policies. To request prior authorization for prescription drugs, please visit UHA's website: uhahealth.com/page/prior-authorization-forms and submit through Express PAth.

1. CPT 11980 (Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin) does not require prior authorization.
2. CPT 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance of drug); subcutaneous or intramuscular [when used to administer feminizing hormones or topical/oral masculinizing hormones] does not require prior authorization.

C. Prior Authorization is required for breast cancer screening in biological males who are taking feminizing hormones for treatment of gender dysphoria.

D. Prior Authorization is required for cytological screening of the neocervix.

E. Prior Authorization is required for mastectomy for treatment of gender dysphoria. Include a referral letter from a qualified mental health professional containing the following:

1. Description of 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 of evaluation and therapy or counseling to date;
4. An explanation that the criteria in II.D.1-5 have been met and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement that informed consent has been obtained from the patient; and
6. A statement that the health care professionals are available for coordination of care.

F. Prior Authorization is required for genital reassignment surgery. Include the following:

1. Two referrals from qualified health care professionals who have independently assessed the patient. One referral must be from the patient's psychotherapist, and the second referral must be from the physician supervising the patient's continuous hormone therapy. A single letter signed by both professionals is sufficient. The referral letter(s) should include the following:
    a. Description of the patient's general identifying characteristics;
    b. Results of the patient's psychosocial assessment, including any diagnoses;
    c. Duration of the mental health professional's relationship with the patient, including the type of evaluation and therapy or counseling to date;
    d. An explanation that the applicable criteria within this policy have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
    e. A statement that informed consent has been obtained from the patient; and
    f. A statement that the health care professionals are available for coordination of care.
2. Documentation that the patient has completed a minimum of 12 months of continuous hormone replacement therapy (unless contraindicated);
3. Documentation that the patient has completed at least 12 months of successful continuous full-time real-life experience in their gender identity, across a wide span of life experiences and events that may occur throughout the year; and

    Note: The patient may complete 12 months of continuous hormone replacement therapy and 12 months of real-life experience in their gender identity concurrently.
4. Prior Authorization is required for all surgical procedures for treatment of gender dysphoria and gender identity disorder.

G. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

H. Include adequate documentation to support the medical necessity of the surgical procedure(s).

CPT Codes requiring prior authorization (not a complete list):

CPT Code	Description
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19325	Mammaplasty, augmentation; with prosthetic implant

53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture (e.g., Johannsen type)
53405	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous 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
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55899	Unlisted procedure, male genital system [used for phalloplasty]
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall;
57107	Vaginectomy, partial removal of vaginal wall; with removal of 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)
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance of drug); subcutaneous or intramuscular [when used to administer puberty suppressing drugs or injected/implanted masculinizing hormones]

HCPCS Codes requiring prior authorization (not a complete list):

HCPCS Code	Description
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

Appendix A

Characteristics of a Qualified Mental Health Professional:

A. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country;

B. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases for diagnostic purposes;

C. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria;

D. Documented supervised training and competence in psychotherapy or counseling;

E. Knowledgeable about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and

F. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

Appendix B

DSM-5 Criteria for Gender Dysphoria in Adults and Adolescents:

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

    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, 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 (or, 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.

DSM-5 Criteria for Gender Dysphoria in Children:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by six or more of the following (one of which must be criterion A.1.)

    1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender, different from one's assigned gender).
    2. In boys (assigned gender), a strong preference for cross dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing of typical feminine clothing.
    3. A strong preference for cross-gender roles in make-believe play or fantasy play.
    4. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough and tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong dislike for the primary and/or secondary sex characteristics that match one's experienced gender.

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

VI. Policy History

Policy Number: MPP-0125-171201

Current Effective Date: 03/01/2019

Original Document Effective Date: 12/01/2017

Previous Revision Dates: 03/19/2018

PAC Approved Date: 11/07/2017

References

1. HMSA Medical Payment Policy (prevailing plan) **Policy Number:** MM.06.026

   World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual Transgender, and Gender Nonconforming people. 2012 7th version.
2. Eldh J, Berg A, Gustafsson M. Long-term follow up after sex reassignment surgery. Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery 1997; 31(1): 39-45.
3. Landén M, Wålinder J, Lundström B. Clinical characteristics of a total cohort of female and male applicants for sex reassignment: A descriptive study. Acta Psychiatrica Scandinavica 1998; 97(3): 189-194.
4. Day P. Trans-gender reassignment surgery. New Zealand health technology assessment (NZHTA). The clearing house for health outcomes and Health technology assessment. February 2002; Volume 1 Number 1.
5. American Psychiatric Association (APA). Gender dysphoria. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: American Psychiatric Publishing; 2013: 451-459.
6. Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at www.transhealth.ucsf.edu/guidelines.
7. Health care for transgender individuals. Committee Opinion No. 512. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:1454-8.