MVP Health Care Medical Policy

Gender Dysphoria Treatment (Commercial and Medicare Products)

Type of Policy:	Surgical
Prior Approval Date:	07/01/2017
Approval Date:	04/06/2020
Effective Date:	06/01/2020
Related Polices:	Breast Implantation Breast Reconstruction Surgery Breast Reduction Surgery Cosmetic and Reconstructive Services Gender Dysphoria Treatment (Medicaid and HARP) Transgender Hormone Policy

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

CPT Codes: 55970, 55980, 57291, 57292, 57335, 55899

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

Experimental codes are not covered.

N/A

Common Diagnosis Codes

ICD-10- CM Diagnosis Codes: F64.1, F64.2, F64.8, F64.9, F66

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

Overview

Gender dysphoria is a complex gender identity condition in which a person feels a strong life-long identification with a gender other than their assigned gender accompanied by a severe sense of discomfort with the person's own gender or a sense of inappropriateness in the gender role of their biological sex. To varying degrees, they adopt the behavior, dress, and mannerisms of a gender other than their assigned gender.

Gender dysphoria diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5): In adolescents and adults gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or 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)

Gender confirmation surgery is a complex process involving multiple medical, psychiatric or psychological counseling, hormonal therapy and surgical modalities to help the candidate for gender confirmation achieve successful behavioral and medical outcomes.

Gender identity is not limited to binary gender identity (exclusively masculine or feminine) but may include non-binary gender identity (a combination of masculine or feminine or neither).

Indications/Criteria

MVP health Care recognizes that gender dysphoria affects people of all genders and is not limited to people with binary gender identities. Coverage of medically necessary services is allowed for binary and non-binary gender identities.

Hormone Therapy

A. Hormone therapy, whether or not in preparation for gender confirmation surgery, is covered as follows:

1. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants), based upon a determination by a qualified medical professional that an individual is eligible and ready for such treatment, that the individual:

   a. meets the criteria for a diagnosis of gender dysphoria;

   b. has experienced puberty to at least Tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria;

   c. does not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment;

   d. has adequate psychological and social support during treatment; and

   e. demonstrates knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment;

2. Treatment with cross-sex hormones for patients who are sixteen (16) years of age and older*, based upon a determination of medical necessity made by a qualified medical professional; patients who are under eighteen (18) years of age must meet the applicable criteria for coverage of pubertal suppressants. .

*Coverage for cross-sex hormones for patients under sixteen years of age who otherwise meet the requirements for pubertal suppressants shall be made in specific cases if medical necessity is demonstrated and prior approval is received. Hormone therapy is necessary if it is appropriate to the enrollee's gender goals, recommended by the enrollee's treating provider, clinically appropriate for the type of surgery requested, not medically contraindicated, and the enrollee is otherwise able to take hormones.

- The member must have prescription drug coverage and is responsible for all applicable copayments and coinsurance as required by their contract, rider or specific benefit design. Hormone therapy is subject to the applicable prescription drug formulary, prior authorization, step therapy and/or quantity limits.

Surgical Gender Confirmation

- Member must be at least 18 years of age or older*.
- Member must have a diagnosis of gender dysphoria.

- Member has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless hormone therapy is medically contraindicated, or the individual is otherwise unable to take hormones. (Hormone therapy is not a prerequisite for mastectomy).
- Member has lived for 12 months in a gender role congruent with the individual's gender identity, and has received mental health counseling, as deemed medically necessary, during that time.
- Member must have the capacity to make a fully informed decision and to consent to treatment.
- Member has no other significant medical or mental health conditions that would contraindicate gender confirmation surgery, or if so, that those conditions are reasonably well-controlled prior to surgery.

* Although the minimum age for coverage of gender confirmation surgery is generally 18 years of age, criteria allow for coverage for individuals less than 18 years of age in specific cases if medical necessity is demonstrated and prior approval is received.

Parental consent is required prior to gender confirmation surgery of a minor.

For members undergoing a hysterectomy, a NYS DOH Sterilization Consent Form LDSS-3113, "Acknowledgement of Receipt of Hysterectomy Information," is required. The form is available at:
https://www.health.ny.gov/health_care/medicaid/publications/docs/ldss/ldss-3134.pdf

Prior to surgery for the treatment of gender dysphoria, the following documentation is required: Letters are required from two licensed health professionals who have independently assessed the individual and are referring the Member for surgery.

- One of letters must be from licensed psychiatrist, or psychologist, or psychiatric nurse practitioner, or licensed clinical social worker with whom the individual has an established and ongoing relationship. The recommendation for surgery in the letter must be based on an independent assessment/evaluation of the Member; and
- One of the letters may be from a licensed psychiatrist, psychologist, psychiatric nurse practitioner, physician, or licensed clinical social worker working within the scope of their practice and who has only had an evaluative role with the individual. The recommendation for surgery in the letter must be based on an independent assessment/evaluation of the Member.

Letters written by the qualified licensed health professionals, who are referring the enrollee for the surgery, service or procedure indicate that the enrollee:

i. Has a persistent and well-documented case of gender dysphoria, and;

ii. Has received hormone therapy appropriate to the enrollee's gender goals, which shall be for a minimum of 12 months in the case of an enrollee seeking genital surgery, unless such therapy is medically contradicted or the enrollee is otherwise unable to take hormones, and;

iii. Has lived for 12 months in a gender role congruent with the enrollee's gender identity and has received mental health counseling as deemed medically necessary by the enrollee's treating NYS licensed health professional. The duration and frequency of mental health counseling is dependent on the enrollee's unique clinical profile and biopsychosocial circumstances. There is no requirement that mental health counseling be provided continuously for 12 months prior to surgery and;

iv. Has no other significant medical or mental health conditions that would be a contraindication to the surgery, or if so, that those are reasonably well-controlled prior to the surgery; and

v. Has the capacity to make a fully informed decision and to consent to the treatment.

Gender Confirmation Surgeries

When all of the above criteria are met, the following genital surgeries are covered:

- orchiectomy: removal of testicles;
- penectomy: removal of penis;
- vaginoplasty: creation of vagina;
- clitoroplasty: creation of clitoris;
- labiaplasty: creation of labia;
- electrolysis when required for phalloplasty or vaginoplasty
- breast augmentation when both of the following are met:
  - the member meets all the criteria for gender confirmation surgery listed in the Indications/Criteria section above, and
  - the member has completed a minimum of 24 months of hormone therapy during which time no breast growth has occurred, or hormone therapy is medically contraindicated, or the patient is otherwise unable to take hormones

- mastectomy and/or reduction mammoplasty* (Hormone therapy is not a prerequisite)
- hysterectomy**: removal of uterus;
- salpingo-oophorectomy***: removal of fallopian tubes and ovaries;
- salpingectomy: removal of fallopian tubes
- oophorectomy: removal of ovaries
- vaginectomy: removal of vagina;
- metoidioplasty: creation of micro-penis, using the clitoris;
- phalloplasty: creation of penis, with or without urethra;
- urethroplasty: creation of urethra within the penis;
- scrotoplasty: creation of scrotum;
- placement of a testicular prostheses: implantation of artificial testes;
- penile prosthesis;

*Mastectomy (CPT code 19303) requires prior authorization for gender confirmation surgery.

**Hysterectomy (CPT codes 58150, 58260, 58262, 58275, 58280, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573) requires prior authorization for gender confirmation surgery

*** Salpingo-oophorectomy (CPT codes 58661, 58720) requires prior authorization for gender confirmation surgery.

Exclusions

- Conversion therapy (counseling and psychotherapy to attempt to change an individual's sexuality) is not considered medically necessary. The medical literature does not support that this treatment is necessary nor is there evidence that sexual orientation or gender identity can be altered through therapy.
- Speech therapy (92508) in a group setting is not covered.
- cryopreservation, storage, and thawing of reproductive tissue, and all related services and charges;
- reversal of genital and/or breast surgery;
- reversal of surgery to revise secondary sex characteristics;
- reversal of any procedure resulting in sterilization; and

- cosmetic surgery, services, and procedures, including but not limited to
    - abdominoplasty, blepharoplasty, neck tightening, or removal of redundant skin;
    - breast, brow, face, or forehead lifts;
    - calf, cheek, chin, nose, or pectoral implants;
    - collagen injections;
    - drugs to promote hair growth or loss;
    - electrolysis, unless required for vaginoplasty or phalloplasty;
    - facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
    - hair transplantation;
    - lip reduction;
    - liposuction;
    - thyroid chondroplasty; and
    - Voice therapy, voice lessons, or voice modification surgery.

Requested services, surgeries, and procedures for the treatment of gender dysphoria shall not be automatically denied on the basis that they are cosmetic in nature but must be reviewed to determine medical necessity for the treatment of the enrollee's gender dysphoria.

- Any other surgeries, services, and procedures in connection with gender confirmation not listed above, or to be performed in situations not described above, including those done to change the patient's physical appearance to more closely conform secondary sex characteristics to those of the patient's identified gender, will be covered if it is demonstrated that such surgery, service, or procedure is medically necessary to treat a particular patient's gender dysphoria, and prior approval is received. Coverage is not available for surgeries, services, or procedures that are purely cosmetic, i.e., that enhance a patient's appearance but are not medically necessary to treat the patient's underlying gender dysphoria.

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Member Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO in Plan	Prior Auth
PPO OOP	Prior Auth
POS in Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
Preferred Gold HMO POS/ GoldValue HMO POS	Prior Auth
Gold PPO	Prior Auth
Gold AnyWhere PPO	Prior Auth
SmartFund MSA	Potential for Retrospective Review
USACare PPO	Potential for Retrospective Review
WellSelect PPO	Prior Auth
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
Student Health Plans	Prior Auth
ASO	See SPD
Vermont Products	
POS in Plan	Prior Auth
POS OOP	Prior Auth
Preferred Gold HMO POS/ GoldValue HMO POS	Prior Auth
GoldSecure HMO POS	Prior Auth
Gold PPO	Prior Auth
Gold AnyWhere PPO	Prior Auth
USACare PPO	Potential for Retrospective Review
WellSelect PPO	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD

♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).

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***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review.
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design