INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs), and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee's specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COVERAGE RATIONALE

Before using this guideline, please check the federal, state or contractual requirements for benefit coverage.

Treatment for gender dysphoria is sometimes referred to as: gender identity disorder treatment, sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex or gender reassignment. These terms are used interchangeably throughout this document, and, for purposes of this document, are intended to have the same meaning.
Throughout this document, the abbreviation WPATH refers to an advocacy group called the World Professional Association for Transgender Health. WPATH notations in this policy refer to the publication, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version.

NON-SURGICAL TREATMENT OF GENDER DYSPHORIA:

Covered Services:
If a plan covers non-surgical treatment for gender dysphoria, the following non-surgical treatment is covered:

1. **Psychotherapy** for gender dysphoria and associated co-morbid psychiatric diagnoses.
   *Note: If mental health services are not covered on the UHC plan (for example when mental health services are carved out of the plan design), the UHC plan will not cover psychotherapy for gender dysphoria.*

Coverage Limitations and Exclusions:
Certain non-surgical treatments are not covered. Examples that apply to this exclusion include, but are not limited to:

1. Treatment received outside of the United States.
2. Non-surgical treatments that are not listed in the Covered Services section above.
3. Reproduction services including, but not limited to: sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus.
4. Voice therapy.
5. Services that exceed the maximum dollar limit on the plan.
6. Transportation, meals, lodging or similar expenses.

Note the following:

1. Certain plans may have a different list of exclusions.
2. Additional exclusions are listed in the surgical treatment section below.

SURGICAL TREATMENT FOR GENDER DYSPHORIA:

Covered Surgical Treatment for Gender Dysphoria:
If a plan covers surgical treatment for gender dysphoria, the following are covered when the Eligibility Qualifications for Surgery are met below:

1. **Genital Surgery** (by various techniques which must be appropriate to each patient), including: complete hysterectomy; orchiectomy; penectomy; vaginoplasty; vaginectomy; clitoroplasty; labiaplasty; salpingo-oophorectomy; metoidioplasty; scrotoplasty; urethroplasty; placement of testicular prosthesis and phalloplasty.

2. **Surgery to change specified secondary sex characteristics**, specifically:
   • Thyroid chondroplasty (removal or reduction of the Adam’s Apple); and
   • Bilateral mastectomy; and
   • Augmentation mammoplasty (including breast prosthesis if necessary) if the physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

3. **Related Services**: In addition to the surgeon fees, the benefit applies to the services related to the surgery, including but not limited to: anesthesia, laboratory testing, pathology, radiologic procedures, hospital and facility fees, and/or surgical center fees.

Eligibility Qualifications for Surgery:
The following criteria apply to genital surgery and to surgery to change specified secondary sex characteristics listed above. It is our expectation that surgery be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder.
If a plan covers surgical treatment for gender dysphoria, the covered person must meet all of the following eligibility qualifications prior to surgery:

1. Persistent, well-documented gender dysphoria (see definition of Gender Identity Disorder below); and
2. Capacity to make a fully informed decision and to consent for treatment; and
3. Age of majority in a given country. Note: WPATH* guidelines address age of majority in a given country. For the purposes of this guideline, the age of majority is age 18. However, this refers to chronological age, not biological age. Where approval or denial of benefits is based solely on the age of the individual a case-by-case medical director review is necessary, and
4. If significant medical or mental health concerns are present, these must be reasonably well-controlled; and
5. The covered person must complete 12 months of successful continuous full time real life experience in the desired gender, and
6. The covered person may be required to complete continuous hormone therapy (for those without contraindications). In consultation with the patient’s physician, this should be determined on a case-by-case basis through the Notification process; and
7. The treatment plan must conform to identifiable external sources including the World Professional Association for Transgender Health Association (WPATH) standards, and/or evidence-based professional society guidance.

Clarifications for Breast/Chest Surgery:
In addition to the Eligibility Qualifications for Surgery listed above, please note the following:

1. A biologic female patient that is only requesting a bilateral mastectomy:
   - Does not need to complete hormone therapy in order to qualify for the mastectomy.
   - Although not a requirement for coverage, UnitedHealthcare recommends that the patient complete at least 3 months of psychotherapy before having the mastectomy.
2. A biologic male patient that is only requesting a breast augmentation:
   - If able to take female hormones, the patient should take the female hormones for at least 12 – 24 months* before being considered for bilateral breast augmentation since the patient may achieve adequate breast development without surgery.
   - Although not a requirement for coverage, UnitedHealthcare recommends that the patient complete at least 3 months of psychotherapy before having the breast augmentation.
   * 12 months is listed by WPATH v7, whereas, 2 years is listed by, Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009).

Note the following:
1. Certain plans may have a different list of Covered Services for Treatment of Gender Identity Disorder and may not cover all services listed above.
2. Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.
3. Sterilization surgery is not required in order to receive the covered services under this benefit.

Excluded Services for Surgical Treatment of Gender Dysphoria:
The following are not covered even if the plan includes coverage for surgical treatment for gender dysphoria:
1. Treatment received outside of the United States.
2. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
4. Facial feminization surgery, including but not limited to: facial bone reduction, face “lift”, facial hair removal, and certain facial plastic reconstruction.
5. Suction-assisted lipoplasty of the waist.
6. Rhinoplasty (except if rhinoplasty criteria are met; see the CDG titled *Rhinoplasty and Other Nasal Surgeries*).
7. Blepharoplasty (except if blepharoplasty criteria are met; see the CDG titled *Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair*).
8. Abdominoplasty (except if abdominoplasty criteria are met; see the CDG titled *Panniculectomy & Body Contouring Procedures*).
9. Breast reduction (except if breast reduction criteria are met; see the CDG titled *Breast Reduction Surgery*).
10. For plans that do not cover surgical treatment of gender dysphoria, surgical treatments for gender dysphoria are not covered even if considered to be medically necessary by the prescribing physician or other health practitioner.
11. For plans that cover surgical treatment of gender dysphoria, coverage does not apply to enrollees that do not meet the criteria listed in the *Eligibility Qualifications for Surgery* section above.

Note the following:
1. Certain plans may have a different list of exclusions.
2. Additional exclusions are listed in the non-surgical treatment section above.

**DEFINITIONS**

**Gender Identity Disorder**: A disorder characterized by the following diagnostic criteria:

1. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
2. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
3. The disturbance is not concurrent with a physical intersex condition.
4. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
5. The transsexual identity has been present persistently for at least two years.
6. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

**APPLICABLE CODES**

The Current Procedural Terminology (CPT®) codes and/or Healthcare Common Procedure Coding System (HCPCS) codes listed in this policy are for reference purposes only. Listing of a service code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other policies and coverage determination guidelines may apply. This list of codes may not be all inclusive.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>55970</td>
<td>Intersex surgery; male to female</td>
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<tr>
<td>55980</td>
<td>Intersex surgery; female to male</td>
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*CPT® is a registered trademark of the American Medical Association.*

**NOTE**: CPT codes 55970 & 55980 may be done for congenital defects, genital anomalies, or as a treatment for Gender Identity Disorder.
ICD-9 Codes (Discontinued 10/01/15)
The following list of codes is provided for reference purposes only. Effective October 1, 2015, the Centers for Medicare & Medicaid Services (CMS) implemented ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets. **ICD-9 codes will not be accepted for services provided on or after October 1, 2015.**

<table>
<thead>
<tr>
<th>ICD-9 Diagnosis Code (Discontinued 10/01/15)</th>
<th>Description</th>
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<tbody>
<tr>
<td>302.50 Trans-sexualism with unspecified sexual history</td>
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<tr>
<td>302.51 Trans-sexualism with asexual history</td>
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<td>302.52 Trans-sexualism with homosexual history</td>
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<td>302.53 Trans-sexualism with heterosexual history</td>
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<tr>
<td>302.6 Gender identity disorder in children <strong>Coding Note:</strong> Standard plans do not cover hormone or surgical treatments for the diagnosis of Gender Identity Disorder in children under age 18.</td>
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<tr>
<td>302.85 Gender identity disorder in adolescents or adults</td>
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ICD-10 Codes (Effective 10/01/15)
ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures) must be used to report services provided on or after October 1, 2015. **ICD-10 codes will not be accepted for services provided prior to October 1, 2015.**

<table>
<thead>
<tr>
<th>ICD-10 Diagnosis Code (Effective 10/01/15)</th>
<th>Description</th>
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<tbody>
<tr>
<td>F64.1 Gender identity disorder in adolescence and adulthood <strong>Coding Note:</strong> Standard plans do not cover hormone or surgical treatments for the diagnosis of Gender Identity Disorder in children under age 18.</td>
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<tr>
<td>F64.2 Gender identity disorder of childhood <strong>Coding Note:</strong> Standard plans do not cover hormone or surgical treatments for the diagnosis of Gender Identity Disorder in children under age 18.</td>
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<tr>
<td>F64.8 Other gender identity disorders</td>
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<td>F64.9 Gender identity disorder, unspecified</td>
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<tr>
<td>Z87.890 Personal history of sex reassignment</td>
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</table>

Limited to specific diagnosis codes? □ YES □ NO
The exclusion for gender reassignment treatment is **not** limited to the following diagnosis codes.

**REFERENCES**

1. The World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version.
2. Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

GUIDELINE HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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| 10/01/2015 | • Updated lists of applicable codes; added language to indicate ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures) must be used to report services provided on or after 10/01/2015:  
  o ICD-9 codes will not be accepted for services provided on or after 10/01/2015  
  o ICD-10 codes will not be accepted for services provided prior to 10/01/2015  
• Archived previous policy version CS047.D |