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Gender Identity Services

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Lines of Business: Fed 87; HMO; PPO; QUEST Integration	**Original Effective Date:** January 1, 2016
Place of Service: Outpatient; Inpatient; Office	**Precertification:** Required, refer to Section V

This Policy will apply to Plans upon renewal following the above effective date.

I. Description

Gender identity is defined as a person's internal sense of being male, female, or outside the gender binary. Gender identity develops during early childhood and is understood to be firmly established at age four, although some individuals' gender identity may remain fluid for many years. Gender dysphoria is defined by strong, persistent feelings of dissonance between one's gender identity and assigned gender, accompanied by clinically significant distress or impairment in social or occupational arenas.

Individuals with gender dysphoria sometimes seek counseling to relieve their distress and may decide to undergo certain medical procedures to affirm their gender identities. Since gender identities cover a broad continuum, there is no single path that all individuals take. However, these services are usually completed in a specific order (as determined by a qualified health professional) to ensure that individuals transition safely and effectively.

Individuals diagnosed with gender dysphoria should first be evaluated to determine if they should receive psychotherapy from a mental health professional before receiving any medical treatment. 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. Psychotherapy and hormone therapy are usually considered medically necessary when supported by evidence from preceding treatments.

Some individuals choose to surgically alter their bodies to align with their gender identities. Certain procedures involved in gender affirming genital 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.

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

II. Medical Necessity

In accord with Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), or for Quest members under Hawaii Administrative Rules (HAR 1700.1-42), this Medical Policy provides coverage of services that are medically necessary for the treatment of gender dysphoria, as long as they are not specifically excluded by the Plan. The application of the Policy Criteria (Section III) and Limitations (Section IV) set forth in this Medical Policy shall consider the characteristics of the individual in determining the medical necessity of the services requested.

III. Policy Criteria

A. Psychotherapy and/or sexual identification counseling are covered (subject to Limitations and Administrative Guidelines) for treatment of gender dysphoria when **ALL** the following are met:
   1. Services are provided by a qualified mental health professional. Refer to Appendix A for required characteristics.
   2. The individual 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.
   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** the following are met:
   1. The individual has been diagnosed with persistent, well-documented gender dysphoria as defined by the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria (refer to Appendix B) and gender identity disorder as defined by the current *International Classification of Diseases* (ICD) criteria by a qualified health professional (refer to Appendix A).
   2. The individual has exhibited the first physical changes of puberty, indicated by a minimum Tanner stage of 2.
   3. Clinical records document that the individual assents to treatment and the parent/guardian has made a fully informed decision and consents to treatment.
   4. Comorbid medical and mental health conditions (if present) are reasonably well-controlled.
   5. 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** the following are met:
   1. The individual is at least 16 years of age. If aged < 16 years, the treating clinician must submit documentation of the rationale for clinical inappropriateness of requiring the individual to meet this criterion.
   2. The individual has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (refer to Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified health professional (refer to Appendix A).
   3. Clinical records document that the individual has made a fully informed decision and:
      a. If aged ≥ 18 years, consents to treatment; or
      b. If aged < 18 years, assents to treatment and a parent/guardian consents to treatment.
   4. Comorbid medical and mental health conditions (if present) are reasonably well-controlled.
   5. Continuous hormone replacement therapy will be administered in a safe, appropriate, medically supervised manner.

D. Fertility counseling is covered (subject to Limitations and Administrative Guidelines) when **ALL** the following are met:
   1. Fertility counseling is provided by a qualified health care professional.
   2. Fertility counseling is provided prior to removal of testes or ovaries.
   3. The counselor documents that the individual has been advised about contraceptive use, effects of transition on fertility, and options for fertility preservation and reproduction.

E. Subcutaneous mastectomy, including nipple reconstruction if appropriate, is covered (subject to Limitations and Administrative Guidelines) when **ALL** the following are met:
   1. The individual is at least 16 years of age. If aged < 16 years, the treating clinician must submit submit documentation of the rationale for clinical inappropriateness of requiring the individual to meet this criterion.
   2. The individual has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (refer to Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified health professional (refer to Appendix A).
   3. Clinical records document that the individual has made a fully informed decision and:
      a. If aged ≥ 18 years, consents to treatment; or
      b. If aged < 18 years, assents to treatment and a parent/guardian consents to treatment.
   4. Comorbid medical and mental health conditions (if present) are reasonably well-controlled.
   5. The individual has obtained a referral letter from a qualified mental health professional (refer to Appendix A).

F. Gender affirming breast augmentation procedures are covered (subject to Limitations and Administrative Guidelines) when **ALL** the following are met:
   1. For individuals without a medical contraindication or intolerance, the individual has undergone a minimum of 12 months of continuous hormonal therapy.
   2. Existing chest appearance demonstrates significant variation from normal appearance for the experienced gender.
   3. The individual is at least 16 years of age. If aged < 16 years, the treating clinician must submit information indicating why it would be clinically inappropriate to require the candidate to meet this criterion.
   4. The individual has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (refer to Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified health professional (refer to Appendix A).
   5. Clinical records document that the individual has made a fully informed decision and:
      a. If aged ≥ 18 years, consents to treatment; or
      b. If aged < 18 years, assents to treatment and a parent/guardian consents to treatment.
   6. Comorbid medical and mental health conditions (if present) are reasonably well-controlled.
   7. The individual has obtained a referral letter from a qualified mental health professional (refer to Appendix A).

G. Gender affirming genital surgery is covered (subject to Limitations and Administrative Guidelines) when **ALL** the following are met:
   1. The individual is at least 18 years of age.
   2. The individual has been diagnosed with persistent, well-documented gender dysphoria as defined by the current DSM criteria (refer to Appendix B) and gender identity disorder as defined by the current ICD criteria by a qualified health professional (refer to Appendix A).
   3. The individual has completed a minimum of 12 months of continuous hormonal therapy (unless contraindicated or hormone therapy is undesired by patient) when recommended by a qualified health professional and provided under the supervision of a physician.

4. The individual has lived continuously for at least 12 months in the gender role that is congruent with their gender identity. Note: The patient may complete 12 months of continuous hormone therapy and 12 months of real- life experience in their gender congruent identity concurrently.
5. Clinical records document that the individual made a fully informed decision and consents to treatment.
6. Comorbid medical and mental health conditions (if present) are reasonably well-controlled.
7. The individual has obtained referral letters from two qualified health care professionals.
    a. One letter must be the psychotherapist who has established the gender dysphoria and gender identity disorder diagnosis.
    b. The other letter must be from the physician, nurse practitioner (NP), or advanced practice registered nurse (APRN) supervising the continuous hormone replacement therapy (if applicable). For an individual not receiving continuous hormone replacement therapy, a referral letter from the physician/NP/APRN supervising the individual's gender-related health is required.

H. Hair removal treatments are covered (subject to Limitations and Administrative Guidelines) for hair removal on a skin graft prior to gender affirming genital surgery when criteria for gender affirming genital surgery have been met and gender affirming genital surgery has been approved.
    1. Laser hair removal on a skin graft prior to gender affirming genital surgery is covered when there is documentation of the graft site, i.e., diagram(s) detailing the specific area of hair removal.
    2. Electrolysis is covered (subject to Limitations, Administrative Guidelines and Guide to Benefits (GTB)) when **BOTH** the following are met:
        a. There is documentation from a dermatologist that laser hair removal is not indicated due to hair color.
        b. There is documentation of graft site, i.e., diagram(s) detailing the specific area of hair removal.
I. Surgical revisions and reconstructive surgeries following gender affirmation surgery are covered (subject to Limitations and Administrative Guidelines) when **ONE** of the following is met:
    1. Surgery is medically necessary to correct complication(s) resulting from the initial surgery.
    2. Surgery is performed to correct functional impairment resulting from the initial surgery.
J. Preventive services are covered (subject to Limitations and Administrative Guidelines) in the following situations:
    1. Cancer screening services for individuals 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 refer to the relevant HMSA policy for coverage criteria.
    2. Screening for breast cancer for transgender females who have been on feminizing hormones for at least 5 years, in accordance with breast-screening guidelines recommended for those designated female at birth.
    3. Routine cytological examination of the neocervix for individuals who have had a neocervix created from the glans penis.

IV. Limitations

A. Gender identity services provided outside the United States are not covered.
B. Hair removal services are limited as follows:
    1. Hair removal services, including electrolysis and laser, are not covered other than as outlined in III.G above (e.g., facial, underarm, leg, etc.).
    2. Electrolysis is covered only for individuals for whom laser hair removal is not indicated, i.e., due to hair color.

C. Reconstructive surgery following gender affirmation surgery to reverse natural signs of aging or if the member is not satisfied with the surgical result is not covered because it is not known to improve health outcomes.

V. Administrative Guidelines

A. Precertification is not required for the following services. HMSA reserves the right to perform retrospective reviews using the above criteria to validate whether services rendered met payment determination criteria. Relevant documentation for gender identity services received should be maintained in the patient's medical records, as it may be necessary for the patient to qualify for coverage for additional transition-related interventions.
   1. Psychotherapy, sexual identity counseling, or fertility counseling for treatment of gender dysphoria.
   2. Feminizing hormones (e.g., estrogens, antiandrogens) and testosterone products when administered as an intramuscular injection, depot injection, pellets, or subcutaneous implant. For all other testosterone products (e.g., administered as a transdermal film, transdermal gel, topical solution, nasal gel, buccal tablet, etc.) quantity limits may apply. Please review HMSA formulary quarterly.
   3. Breast cancer screening in individuals assigned male at birth who are taking feminizing hormones for treatment of gender dysphoria.
   4. Cytological screening of the neocervix.

B. Precertification is required for the following services. To precertify, complete HMSA's Precertification Request and mail or fax the form along with the applicable documentation as indicated.
   1. Hair removal services on a skin graft prior to genital confirmation surgery.
   2. Puberty suppression therapy through CVS. Please review relevant criteria in the applicable CVS policies.
   3. Subcutaneous mastectomy including nipple reconstruction (if appropriate). A referral letter from a qualified mental health professional containing the following must be submitted:
      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 criteria in III.E.1-5 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.
   4. Breast augmentation procedures. A referral letter from a qualified mental health professional containing the following must be submitted:
      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 criteria in II.F. 1.-7. have been met, and a brief description of the clinical rationale 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.
   5. Gender affirming genital surgery. The following must be submitted:
      a. Two referrals from qualified health care professionals who have independently assessed the patient. One referral must be from the patient's qualified mental health professional and the

second referral must be from the physician/NP/APRN supervising the patient's continuous hormone therapy (if applicable). For a patient not receiving continuous hormone replacement therapy, a referral letter from the physician/NP/APRN supervising the patient's gender related health is required. A single letter signed by both professionals is sufficient. The referral letter(s) should include **ALL** the following:

i. Description of the patient's general identifying characteristics
ii. Results of the patient's psychosocial assessment, including any diagnoses
iii. Duration of the mental health professional's relationship with the patient, including the type of evaluation and therapy or counseling to date
iv. An explanation that the criteria in II.F.1-7 have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery.
v. A statement that informed consent has been obtained.
vi. A statement that the health care professionals are available for coordination of care.

b. Documentation that the patient has completed a minimum of 12 months of continuous hormone replacement therapy (unless contraindicated or hormone therapy is undesired by patient).
c. 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. Note: The patient may complete 12 months of continuous hormone replacement therapy and 12 months of real-life experience in their gender identity concurrently.

6. Precertification is required for all surgical procedures for treatment of gender dysphoria. To precertify complete HMSA's Precertification Request and mail or fax the form as indicated. Include adequate documentation to support the medical necessity of the surgical procedure(s).
7. If the patient does not meet HMSA's guidelines for coverage but has indicated that he or she wants the services performed despite noncoverage, the patient should be asked to sign HMSA's Agreement of Financial Responsibility. A signed waiver indicates that the patient will be responsible for the denied charges.
   a. When submitting a claim for services that do not meet HMSA guidelines, append modifier GA to the CPT code for the service. The use of the GA modifier will alert HMSA that the service should be processed to indicate that the patient will be financially responsible, and that the noncovered charges should not be a provider adjustment.
   b. The signed waiver should be kept in the patient's record. HMSA reserves the right to conduct periodic audits on claims submitted with the GA modifier and review medical records for signed waivers for this service.

C. Applicable codes

Codes Requiring Precertification (Not a Complete List)

CPT Code	Description
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue (Use for laser hair removal)
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples

19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap
19367	Breast reconstruction; with single-pedicled TRAM flap
19368	Breast reconstruction; with TRAM flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled TRAM flap
19370	Revision of peri-implant
19371	Peri-implant capsulectomy
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast 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 250g or less
58262	Vaginal hysterectomy, for uterus 250g 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 250g
58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; 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

HCPCS Code	Description
C1789	Prosthesis, breast (Implantable)
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable
L8600	Implantable breast prosthesis, silicone or equal

ICD-10-PCS Code	Description
0UQG0ZZ	Repair vagina, open approach
0UQJ0ZZ-0UQJXZZ	Repair clitoris [by approach; includes codes 0UQJ0ZZ, 0UQJXZZ]
0UT20ZZ-0UT2FZZ	Resection of bilateral ovaries [by approach; includes codes 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ]
0UT70ZZ-0UT7FZZ	Resection of bilateral fallopian tubes [by approach; includes codes 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ]
0UT90ZZ-0UT9FZZ	Resection of uterus [by approach; includes codes 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ]
0UTC0ZZ-0UTC8ZZ	Resection of cervix [by approach; includes codes 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ]
0UTG0ZZ-0UTG8ZZ	Resection of vagina [by approach; includes codes 0UTG0ZZ, 0UTG4ZZ, 0UTG7ZZ, 0UTG8ZZ]
0UTJ0ZZ-0UTJXZZ	Resection of clitoris [by approach; includes codes 0UTJ0ZZ, 0UTJXZZ]
0UTM0ZZ-0UTMXZZ	Resection of vulva [by approach; includes codes 0UTM0ZZ, 0UTMXZZ]
0VRC0JZ	Replacement of bilateral testes with synthetic substitute, open approach
0VTC0ZZ-0VTC4ZZ	Resection of bilateral testes [by approach; includes codes 0VTC0ZZ, 0VTC4ZZ]
0VTS0ZZ-0VTSXZZ	Resection of penis [by approach; includes codes 0VTS0ZZ, 0VTS4ZZ, 0VTSXZZ]
0VUS07Z-0VUSX7Z	Supplement penis with autologous tissue substitute [by approach, includes codes 0VUS07Z, 0VUS47Z, 0VUSX7Z]
0VUS0KZ-0VUSXKZ	Supplement penis with nonautologous tissue substitute [by approach; includes codes 0VUS0KZ, 0VUS4KZ, 0VUSXKZ]
0W4M070	Creation of vagina in male perineum with autologous tissue substitute, open approach
0W4M0J0	Creation of vagina in male perineum with synthetic substitute, open approach
0W4M0K0	Creation of vagina in male perineum with nonautologous tissue substitute, open approach
0W4M0Z0	Creation of vagina in male perineum, open approach
0W4N071	Creation of penis in female perineum with autologous tissue substitute, open approach
0W4N0J1	Creation of penis in female perineum with synthetic substitute, open approach
0W4N0K1	Creation of penis in female perineum with nonautologous tissue substitute, open approach
0W4N0Z1	Creation of penis in female perineum, open approach

Codes Not Requiring Precertification

CPT Code	Description
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient and/or family member
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance of drug); subcutaneous or intramuscular [when used to administer feminizing hormones or topical/oral masculinizing hormones]

Codes Covered Only When Shown to be Medically Necessary (Not a Complete List)*

CPT Code	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	1.1 to 5.0 cc
11952	5.1 to 10.0 cc
11954	over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	segmental, face
15782	regional, other than face
15783	superficial, any site
15788	Chemical peel, facial; epidermal
15789	dermal
15792	Chemical peel, nonfacial; epidermal
15793	dermal
15822	Blepharoplasty, upper eyelid
15823	with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	neck with platysmal tightening (platysmal flap, P-flap)
15826	glabellar frown lines
15828	cheek, chin, and neck
15829	superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	thigh
15833	leg
15834	hip
15835	buttock
15836	arm

15837	forearm or hand
15838	submental fat pad
15839	other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	trunk
15878	upper extremity
15879	lower extremity
19316	Mastopexy
19318	Reduction mammaplasty
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	sliding osteotomy, single piece
21122	sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	intermediate revision (bony work with osteotomies)
30450	major revision (nasal tip work and osteotomies)
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
31599	Unlisted procedure, larynx [when used for voice modification surgery]
54660	Insertion of testicular prosthesis (separate procedure)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

* Modifier code KX may be used to identify services for transgender members receiving gender affirming services. Modifier KX may be coded with the above services to avoid delays in claims processing. Refer to Modifier Code KX and Condition Code 45 article on HMSA's Provider Resource Center for additional information.

Covered Diagnostic Codes

ICD-10 Code	Description
F64.0	Transsexualism
F64.2	Gender identity disorder of childhood

F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

VI. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), or for Quest members under Hawaii Administrative Rules (HAR 1700.1-42), generally accepted standards of medical practice and review of medical literature and government approval status.

If a treating physician disagrees with HMSA's determination of medical necessity, the physician may request that HMSA reconsider the application of the medical necessity criteria by providing additional supporting documentation (e.g., clinical records, scientific evidence, professional journal articles).

VII. Appendices

A. Appendix A: Qualified Health Professionals

1. 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
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.

2. Characteristics of a Qualified Healthcare Provider

a. Holds an MD/DO, NP or APRN degree granted by an institution accredited by the appropriate national and/or regional accrediting board(s) and maintains an active Licensed in their State of practice.
b. Has competence in using the DSM and/or the ICD for diagnostic purposes.

c. Has the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.,* body dysmorphic disorder).
d. Has received training in diagnosing RELATED psychiatric conditions.
e. Has the ability to undertake or refer for appropriate treatment.
f. Has the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy.
g. Maintains a practice of regularly attending relevant professional meetings.

B. Appendix B: DSM-5 Criteria for Gender Dysphoria

1. DSM-5 Criteria for Gender Dysphoria in Adults and Adolescents

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:

a. 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).
b. 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).
c. A strong desire for the primary and/or secondary sex characteristics of the other gender.
d. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
f. 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).
g. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

2. DSM-5 Criteria for Gender Dysphoria in Children

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.):

a. 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).
b. 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.
c. A strong preference for cross-gender roles in make-believe play or fantasy play.
d. A strong preference for toys, games, or activities stereotypically used or engaged in by the other gender.
e. A strong preference for playmates of the other gender.
f. 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.
g. A strong dislike of one's sexual anatomy.

h. A strong dislike for the primary and/or secondary sex characteristics that match one's experienced gender.
i. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

VIII. References

1. World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transgender and Gender Diverse People. Version 8.
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8. Hembree W, Cohen-Kettenis P et. al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolis* vol 102 issue 11. 11/1/17 pg. 3869-3909.

X. Policy History

Action Date	Action
January 11, 2015	Policy reviewed by Medical Director Mark Mugiishi, M.D.
April 11, 2015	Policy approved at OMD
April 28, 2015	Policy approved by UMC
August 5, 2016	Policy reviewed by Medical Director Kenneth Luke, M.D.
August 11, 2016	Policy reviewed by Gender Identity Workgroup
August 15, 2016	Policy reviewed by Policy Workgroup
August 16, 2016	Policy approved at OMD
August 26, 2016	Policy approved by UMC
July 26, 2017	Policy reviewed by Medical Director Kenneth Luke, M.D.
August 8, 2017	Policy reviewed by Policy Workgroup
August 15, 2017	Policy approved at OMD
August 25, 2017	Policy approved by UMC
December 3, 2018	Policy reviewed by Medical Director Cristeta Ancog, M.D.
December 18, 2018	Policy approved at OMD
December 21 2018	Policy approved by UMC
July 15, 2019	Policy reviewed by Medical Director Cristeta Ancog, M.D.
August 6, 2019	Policy approved at OMD
August 23, 2019	Policy approved by UMC
October 1, 2020	Policy reviewed by Medical Director Cristeta Ancog, M.D.

November 17, 2020	Policy approved at OMD
November 20, 2020	Policy approved by UMC
March 01, 2021	Policy effective date after the notification period
March 09, 2021	Policy reviewed by Medical Director Cristeta Ancog, M.D. Pre-surgical skin graft hair removal coverage updated.
March 16, 2021	Policy approved at OMD
March 26, 2021	Policy approved by UMC
November 9, 2021	Policy reviewed by Medical Director Cristeta Ancog, M.D.
November 16, 2021	Policy approved at OMD
November 9, 2021	Policy approved by UMC
May 01, 2022	Policy effective date following notification period
August 01, 2022	Policy updated for consistency; policy statement unchanged. Policy effective date unchanged.
November 29, 2022	Policy reviewed by Medical Director Cristeta Ancog, M.D.
December 06, 2022	Policy approved at OMD
December 16, 2022	Policy approved by UMC
May 01, 2023	Policy effective date following notification period
November 28, 2023	Policy reviewed by Medical Director Cristeta Ancog, M.D.
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December 15, 2023	Policy approved by UMC