Gender Dysphoria Treatment (for Pennsylvania Only)

Policy Number: CS145PA.M
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Instructions for Use

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Application

This Medical Policy only applies to the state of Pennsylvania. Any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis. Refer to Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101.

Coverage Rationale

See Benefit Considerations

Note: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

Note: The Pennsylvania Department of Human Services requires managed care plans to determine medical necessity for Gender Dysphoria treatment services based on the most recent version of the World Professional Association of Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People. Current Standard of Care guidelines can be found here: https://www.wpath.org/publications/soc.

Criteria for Adults

Surgical treatment for Gender Dysphoria may be indicated when the following criteria are met, as documented in an assessment from a health care professional who has competencies in the assessment of transgender people:

- Gender incongruence is marked and sustained
- Meets diagnostic criteria for gender incongruence
- Demonstrates capacity to consent for the specific gender-affirming surgical intervention

- Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options
- Other possible causes of apparent gender incongruence have been identified and excluded
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed
- Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated)

Surgical treatment for individuals seeking to detransition or retransition may be indicated when, in addition to the applicable criteria above, the following criteria are met:

- Documentation of a comprehensive multidisciplinary assessment by health care professionals experienced in transgender health. The assessment must be inclusive of, but not limited to, the following:
  - Exploration of concerns with previous physical changes and efforts to ensure similar concerns are not replicated by further physical changes
  - A recommended period of living in role before further physical changes are recommended
  - Evaluation of the etiology of regret, if applicable, as well as the temporal stability of the surgical request

Criteria for Adolescents

Surgical treatment for Gender Dysphoria may be indicated when the following criteria are met, as documented in an assessment from a member of a multidisciplinary team, including both medical and mental health professionals, reflecting the assessment, and opinion from the team:

- Gender diversity/incongruence is marked and sustained over time
- Meets the diagnostic criteria of gender incongruence
- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally
- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility
- At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated

When the applicable criteria above are met for Adults/Adolescents, surgical procedures listed in WPATH, Version B, Appendix E and otherwise included within the scope of covered benefits may be medically necessary. Refer to the Benefit Considerations section as federal, state, or contractual requirements may vary.

Definitions

Gender Dysphoria in Adolescents and Adults: A disorder characterized by the following diagnostic criteria [Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision (DSM-5- TR™)]:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least two** of the following:
  1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (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)

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

Gender Dysphoria in Children: A disorder characterized by the following diagnostic criteria [Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision (DSM-5- TR™)]:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least six** of the following (**one of which must be criterion A1**):
  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 the 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 the 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 ones' sexual anatomy
  8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender
- The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements 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 claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15750	Flap; neurovascular pedicle
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)

CPT Code	Description
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes

CPT Code	Description
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
21899	Unlisted procedure, neck or thorax
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete

CPT Code	Description
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
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
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
57110	Vaginectomy, complete removal of vaginal wall
57335	Vaginoplasty for intersex state
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)
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)

CPT Code	Description
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
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

Diagnosis Code	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
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

Description of Services

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed/alternative gender and assigned gender (DSM-5- TR). Gender-affirming care encompasses a range of social, psychological, behavioral, and medical interventions to support an individual's gender identity. Treatment options include behavioral therapy, psychotherapy, hormone therapy, and surgery for gender transformation. Surgical treatments for gender dysphoria may include the following: clitoroplasty, hysterectomy, labiaplasty, mastectomy, orchiectomy, penectomy, phalloplasty or metoidioplasty (alternative to phalloplasty), placement of testicular and/or penile prostheses, salpingo-oophorectomy, scrotoplasty, urethroplasty, urethroplasty, vaginectomy, vaginoplasty, and vulvectomy.

Other terms used to describe surgery for gender dysphoria include gender affirming surgery, sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery, and sex reassignment.

Benefit Considerations

Coverage Information

Benefit coverage for health services is determined by the federal, state, or contractual requirements that may require coverage for a specific service.

Unless otherwise specified, if a plan covers treatment for Gender Dysphoria, coverage includes psychotherapy, hormone therapy, puberty suppressing medications, and laboratory testing to monitor the safety of hormone therapy and certain surgical treatments listed in the Coverage Rationale section. Certain plans may not cover all the listed surgical treatments in the Coverage Rationale section above. Refer to the federal, state, or contractual requirements document for details.

Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatments and procedures that are specifically excluded or otherwise do not meet the requirements of a Covered Health Care Service, in the federal, state, or contractual requirements
- Treatment received outside of the United States
- 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 (refer to the federal, state, or contractual requirements for benefit coverage)
- Transportation, meals, lodging, or similar expenses
- Cosmetic procedures (refer to the Medical Policy titled Cosmetic and Reconstructive Procedures (for Pennsylvania Only) and the Coverage Rationale section)

Coverage does not apply to members who do not meet the indications listed in the Coverage Rationale section above.

References

Diagnostic and statistical manual of mental disorders (5th ed.,Text Revision). 2022. Washington, DC: American Psychiatric Association.

Pennsylvania Code and Bulletin, Title 55, Chapter 1101.31. Scope. Available at: http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.31.html&d=reduce. Accessed September 8, 2023.

World Professional Association for Transgender Health (WPATH). Standards of care for the health of transsexual, transgender and gender nonconforming people. 8th edition. 2022. https://www.wpath.org/publications/soc. Accessed September 8, 2023.

Policy History/Revision Information

Date	Summary of Changes

05/01/2024	**Related Policies**
	• Added reference link to the Medical Policy titled:
	  ○ *Breast Reconstruction (for Pennsylvania Only)*
	  ○ *Breast Reduction Surgery (for Pennsylvania Only)*
	  ○ *Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for Pennsylvania Only)*
	• Removed reference link to the Medical Policy titled *Speech Generating Devices (for Pennsylvania Only)*
	Coverage Rationale
	• Revised language to indicate:
	  ○ This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development

Date	Summary of Changes
	○ The Pennsylvania Department of Human Services requires managed care plans to determine medical necessity for Gender Dysphoria treatment services based on the most recent version of the World Professional Association of Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People; current Standard of Care guidelines can be found at https://www.wpath.org/publications/soc ○ When the applicable criteria [listed in the policy] are met for Adults/Adolescents, surgical procedures listed in *WPATH, Version B, Appendix E*, and otherwise included within the scope of covered benefits may be medically necessary; refer to the *Benefit Considerations* section [of the policy] as federal, state, or contractual requirements may vary ***Criteria for Adults*** ○ Surgical treatment for Gender Dysphoria may be indicated when the following criteria are met, as documented in an assessment from a health care professional who has competencies in the assessment of transgender people: ▪ Gender incongruence is marked and sustained ▪ Meets diagnostic criteria for gender incongruence ▪ Demonstrates capacity to consent for the specific gender-affirming surgical intervention ▪ Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options ▪ Other possible causes of apparent gender incongruence have been identified and excluded ▪ Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed ▪ Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated) ○ Surgical treatment for individuals seeking to detransition or retransition may be indicated when, in addition to the applicable criteria above, the following criteria are met: ▪ Documentation of a comprehensive multidisciplinary assessment by health care professionals experienced in transgender health; the assessment must be inclusive of, but not limited to, the following: – Exploration of concerns with previous physical changes and efforts to ensure similar concerns are not replicated by further physical changes – A recommended period of living in role before further physical changes are recommended – Evaluation of the etiology of regret, if applicable, as well as the temporal stability of the surgical request ***Criteria for Adolescents*** ○ Surgical treatment for Gender Dysphoria may be indicated when the following criteria are met, as documented in an assessment from a member of a multidisciplinary team, including both medical and mental health professionals, reflecting the assessment and opinion from the team: ▪ Gender diversity/incongruence is marked and sustained over time ▪ Meets the diagnostic criteria of gender incongruence ▪ Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment ▪ Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed, sufficiently so that gender-affirming medical treatment can be provided optimally ▪ Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility ▪ At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as

Date	Summary of Changes
	part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated **Definitions** • Removed definition of "Qualified Behavioral Health Provider" **Applicable Codes** • Removed CPT codes 19340 and 19342 **Benefit Considerations** ***Coverage Information*** • Added language to indicate certain plans may not cover all the listed surgical treatments in the *Coverage Rationale* section [of the policy]; refer to the federal, state, or contractual requirements document for details • Removed instruction to refer to the Medical Benefit Drug Policy titled *Gonadotropin Releasing Hormone Analogs* ***Limitations and Exclusions*** • Revised list of examples of non-covered treatments and services: ○ Added "treatments and procedures that are specifically excluded, or otherwise do not meet the requirements of a covered health care service, in the federal, state, or contractual requirements ○ Removed "reversal of genital surgery or reversal of surgery to revise secondary sex characteristics" **Supporting Information** • Updated *Description of Services* and *References* sections to reflect the most current information • Removed *Clinical Evidence* and *FDA* sections • Archived previous policy version CS145PA.L

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies 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.