Gender Dysphoria Treatment (for New Jersey Only)

Policy Number: CS145NJ.J
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Instructions for Use

Table of Contents **Page**

Related Policies

- Botulinum Toxins A and B
- Brow Ptosis and Eyelid Repair (for New Jersey Only)
- Cosmetic and Reconstructive Procedures (for New Jersey Only)
- Gonadotropin Releasing Hormone Analogs
- Panniculectomy and Body Contouring Procedures (for New Jersey Only)
- Rhinoplasty and Other Nasal Procedures (for New Jersey Only)
- Speech Language Pathology Services (for New Jersey Only)

Application

This Medical Policy only applies to the state of New Jersey.

Coverage Rationale

See Benefit Considerations

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

Note: The state of New Jersey 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, the following Gender Confirmation surgical procedures and/or therapies to treat Gender Dysphoria are considered medically necessary:

- Bilateral mastectomy or breast reduction*
- Breast augmentation with breast implants or fat transfer
- Clitoroplasty (creation of clitoris)
- Hysterectomy (removal of uterus)
- Labiaplasty (creation of labia)
- Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria
- Metoidioplasty (creation of penis, using clitoris)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prostheses
- Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple)
- Urethroplasty (reconstruction of female urethra)
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vaginoplasty (creation of vagina)
- Voice lessons and/or voice therapy (with or without surgery)
- Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords)
- Vulvectomy (removal of vulva)

Gender affirming surgery is considered an irreversible intervention. Although infrequent, reversal of prior gender affirming surgery may be covered when the medical necessity criteria for the requested treatment above are met.

Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary when performed as part of surgical treatment for Gender Dysphoria. Refer to the Benefit Considerations section as member specific benefit plan language may vary.

- Abdominoplasty [also refer to the Medical Policy titled Panniculectomy and Body Contouring Procedures (for New Jersey Only)]
- Blepharoplasty [also refer to the Medical Policy titled Brow Ptosis and Eyelid Repair (for New Jersey Only)]
- Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) [also refer to the Medical Policy titled Panniculectomy and Body Contouring Procedures (for New Jersey Only)]
- Brow lift
- Calf implants
- Cheek, chin, and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair transplantation
- Injection of fillers or neurotoxins [also refer to the Medical Benefit Drug Policy titled Botulinum Toxins A and B]
- Laser or electrolysis hair removal not related to genital reconstruction
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy) [also refer to the Medical Policy titled Panniculectomy and Body Contouring Procedures (for New Jersey Only)]
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty [also refer to the Medical Policy titled Rhinoplasty and Other Nasal Procedures (for New Jersey Only)]
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)

Definitions

Gender Dysphoria: A medical condition codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM 5), defined as clinically significant distress or impairment related to an incongruence between one's experienced gender and the gender one was thought to be at birth, as manifested by certain criterion. Under the treatment protocol widely accepted by the medical community, medically necessary treatment for gender dysphoria may require steps to help an individual transition from living as one gender to another. Treatment, sometimes referred to as "transition-related care," may include counseling, hormone therapy, and/or a variety of possible surgical treatments, depending on the individualized needs of each patient.

Qualified Healthcare Professional:

- Documented credentials from a relevant licensing board.
- A minimum of a master's degree or equivalent training in a clinical field relevant to the assessment and treatment of Gender Dysphoria.
- Knowledge and experience in treating Gender Dysphoria.

(Coleman et al., 2022; Hembree et al., 2017)

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)
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

CPT Code	Description
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
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)

CPT Code	Description
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
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

CPT Code	Description
*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)
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

Codes labeled with an asterisk (*) are not on the State of New Jersey Medicaid Fee Schedule and therefore may not be covered by the State of New Jersey Medicaid Program.

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. Refer to the federal, state, or contractual requirements for details. Also, for hormone therapy, refer to the Medical Benefit Drug Policy titled Gonadotropin Releasing Hormone Analogs.

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 New Jersey 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

State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and Contract to Provide Services. February 2023. NJ FamilyCare Managed Care Contract Accessed November 29, 2023.

Policy History/Revision Information

Date	Summary of Changes

05/01/2024	**Coverage Rationale**
	• Added language to indicate:
	  ○ The state of New Jersey 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
	  ○ Gender affirming surgery is considered an irreversible intervention; although infrequent, reversal of prior gender affirming surgery may be covered when the medical necessity criteria for the requested treatment [listed in the policy] are met
	• Removed language indicating completion of hormone therapy prior to the breast procedure is not required when bilateral mastectomy or breast reduction is performed as a stand-alone procedure without genital reconstruction procedures
	• Replaced language indicating "the [listed] surgical procedures to treat Gender Dysphoria are medically necessary *and covered as a proven benefit* when the criteria [listed in the policy] are met" with "the [listed] *gender confirmation* surgical procedures *and/or therapies* to treat Gender Dysphoria are *considered* medically necessary when the *applicable* criteria [listed in the policy] are met *for adults/adolescents*"
	• Revised list of gender confirmation surgical procedures and/or therapies considered medically necessary; added:
	  ○ Breast augmentation with breast implants or fat transfer
	  ○ Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple)
	  ○ Voice lessons and/or voice therapy (with or without surgery)
	  ○ Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords)
	• Revised list of ancillary procedures considered cosmetic and not medically necessary; removed:
	  ○ Breast enlargement, including augmentation mammaplasty and breast implants
	  ○ Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
	  ○ Voice lessons and voice therapy
	  ○ Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords)
	Criteria for Adults
	• Revised language to indicate:
	  ○ 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

Date	Summary of Changes
	▪ 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*** • Revised language to indicate: ○ 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 **Definitions** • Added definition of “Qualified Healthcare Professional” • Removed definition of “Qualified Behavioral Health Provider” • Updated definition of “Gender Dysphoria” **Applicable Codes** • Removed CPT codes 19340 and 19342 • Added notation to indicate CPT code 92508 is not on the State of New Jersey Medicaid Fee Schedule and therefore may not be covered by the State of New Jersey Medicaid Program • Removed notation indicating CPT codes 17999 and 21899 are not on the State of New Jersey Medicaid Fee Schedule and therefore may not be covered by the State of New Jersey Medicaid Program **Benefit Considerations** ***Coverage Information*** • Added instruction to refer to the federal, state, or contractual requirements for [coverage] details ***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”

Date	Summary of Changes
	○ 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 CS145NJ.I

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.