INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don't have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®.

INSTRUCTIONS FOR USE

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply.

Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that 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.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

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1 Optum is a brand used by United Behavioral Health and its affiliates.
Available benefits for Gender Dysphoria include the following levels of care, procedures, and conditions:

- **Levels of Care**
  - Inpatient
  - Intensive Outpatient Program
  - Outpatient
  - Partial Hospital Program
  - Residential Treatment Facility

- **Procedures**
  - Diagnosis, evaluation, assessment, and treatment planning
  - Treatment and/or procedures
  - Medication management and other associated treatments
  - Individual, family, and group therapy
  - Provider-based case management
  - Crisis intervention

- **Conditions**
  - Depressive Disorders classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* that are not excluded from coverage.

### Indications for Coverage

The requested service or procedure must be reviewed against the language in the member’s benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

**Qualified behavioral health provider** roles and qualifications:

- The behavioral health provider is called on to accurately evaluate and diagnose gender dysphoria and any comorbid conditions, to educate the patient and family, to counsel on the range of treatment options, to ascertain readiness for hormone and surgical therapy, to make formal recommendations to medical and surgical colleagues as part of the team of care, and to provide follow-up (APA Task Force on Gender Identity, 2012; Levine, et al 2013; Vance, et al 2014).

- Recommended minimum credentials for behavioral health providers working with adults presenting with gender dysphoria (WPATH Guidelines, version 7, 2011):
  - A minimum of a master’s degree or its equivalent in a clinical behavioral science field. This degree should be granted by an institution accredited by the appropriate national or regional accrediting board. The behavioral health provider should have documented credentials from a relevant licensing board;
  - Competence in using the current version of the Diagnostic Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD) for diagnostic purposes;
  - Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria;
  - Documented supervised training and competence in psychotherapy or counseling;
  - Knowledgeable about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria;
  - Continuing education in the assessment and treatment of gender dysphoria;
  - Develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients.

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2 The term “qualified behavioral health provider” is to be used synonymously with “qualified mental health professional.”

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• Recommended minimum credentials for behavioral health providers working with children or adolescents with gender dysphoria (WPATH Guidelines, version 7, 2011):
  o Meet the competency requirements for behavioral health providers working with adults, as outlined above;
  o Trained in childhood and adolescent developmental psychopathology;
  o Competent in diagnosing and treating children and adolescents with gender dysphoria.

**Diagnostic evaluation and assessment of gender dysphoria:**

- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o [http://www.psychiatry.org](http://www.psychiatry.org) > Psychiatrists > Practice > Clinical Practice Guidelines
- The gender dysphoria evaluation should include (WPATH Guidelines, version 7, 2011; APA Task Force on Gender Identity, 2012):
  o Acknowledging the member’s concerns with a thorough assessment of the presenting dysphoria and any coexisting conditions;
  o Educating the member and family/support system about therapeutic options as well as their strengths, limitations or misperceptions;
  o Exploring the history, nature and characteristics of the member’s gender identity in order to accurately diagnose the member;
  o Evaluating the member’s emotional functioning, peer and other social relationships, school/occupational functioning, and the strengths and weaknesses of family functioning;
  o Identifying and ensuring that mental health concerns in the caregivers and difficulties in their relationship with the member are adequately addressed.

- The gender dysphoria evaluation considers the following age and developmental factors:
  o Children as young as age 2 may show features that could indicate gender dysphoria, often accompanied by the preference of toys, clothes and games most associated with the other sex (WPATH Guidelines, version 7, 2011).
  o In children, nonconforming behaviors may or may not accompany persistent and severe discomfort with primary sex characteristics (WPATH Guidelines, version 7, 2011).
    ▪ Gender nonconforming behaviors in children may continue into adulthood but may not necessarily be indicative of gender dysphoria and the need for treatment.
    ▪ In most children, gender dysphoria will disappear before or early in puberty, but for a small few, these feelings will intensify and body aversion will develop or increase with the onset of and after puberty.
  o Assessment of the safety of the family, school and community environments in terms of bullying and stigmatization related to gender atypicality, and suitable protective measures is appropriate (APA Task Force on Gender Identity, 2012).
  o Gender nonconformity at any age or developmental level is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition (APA Gender Dysphoria Fact Sheet, 2013).

- The diagnostic process should establish that the patient fulfills diagnostic criteria for gender dysphoria and evaluates for concurrent mental health conditions which may interfere with the treatment, put the patient at risk for negative outcomes or regrets, or require additional treatment (Menveille & Gomez-Lobo, 2011).
  o The provider should be aware that many transgender individuals face significant mental health issues including depression, suicidality, anxiety, body image issues, substance abuse, and posttraumatic stress disorder (Olson, et al 2011)
  o Elevated emotional and behavioral problems, such as anxiety, disruptive, lack of impulse control, and depression may occur in children due to non-acceptance of gender variance (DSM-5, 2013).
  o Anxiety and depressive disorders in adolescents and adults are most common (DSM-5, 2013).
  o Providers should inquire about circumstances commonly encountered by individuals with sexual and gender minority status that confer increased psychiatric risk, such as bullying, suicidal thoughts and/or attempts, high-risk behaviors, substance abuse, and HIV/AIDS and other sexually transmitted illnesses (AACAP Practice Parameter, 2012).
• Differential diagnosis – gender dysphoria should be distinguished from (DSM-5, 2013):
  o Simple nonconformity to stereotypical gender role behavior;
  o Transvestic disorder, characterized by sexual excitement as a result of cross-dressing, which may cause distress or impairment but one’s gender is not questioned;
  o Body dysmorphic disorder, which focuses on the alteration or removal of a specific body part because of its perceived abnormality without rejecting the assigned gender;
  o Schizophrenia or other psychotic disorders, which may rarely include delusions of belonging to another gender.
• The provider uses the findings of the evaluation to assign the appropriate diagnosis, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
  o Diagnosis of gender identity disorder should be made by a qualified behavioral health provider. For children and adolescents, this professional should also have training in child and adolescent developmental psychopathology (Hembree, et al 2009).
  o It is recommended that assessment and accurate DSM diagnosis include the use of validated questionnaires and other validated assessment instruments (APA Task Force on Gender Identity, 2012)
  o The diagnostic name gender dysphoria aims to describe the symptoms and behaviors that identified individuals experience without jeopardizing their access to effective treatment options (APA Gender Dysphoria Fact Sheet, 2013).

**Treatment of individuals with gender dysphoria:**
• When gender incongruence requires further exploration or other psychological, psychiatric, and/or family problems exist, some form of mental health treatment, such as psychotherapy, family therapy, or counseling should be offered. Examples may include gender confusion, negative impact of stigma, poor body image, aversion towards sexuality, or coexisting psychiatric disorders (Cohen-Kettenis & Klink, 2015).
  o Treatment includes a component of age and developmentally appropriate psychoeducation provided to the member (APA Task Force on Gender Identity, 2012).
  o Insight-oriented and supportive psychotherapy are common and often focus on addressing the member’s distress related to the dysphoria and ameliorating any other psychosocial difficulties (APA Task Force on Gender Identity, 2012).
  o Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents when choosing the treatment goals and modality (AACAP Practice Parameter, 2012)
  o Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful (AACAP Practice Parameter, 2012)
• When treating children and adolescents, adequate psychoeducation and counseling to the member’s family and/or caregivers will allow them to develop an accepting and nurturing response to the member’s dysphoria, to choose a course of action, and to give fully informed consent to any treatment chosen (WPATH Guidelines, version 7, 2011; Menvielle & Gomez-Lobo, 2011). This entails disclosure of (APA Task Force on Gender Identity, 2012):
  o The full range of treatment options available (including those that might conflict with the clinician’s beliefs and values),
  o The limitations of the evidence-base that informs treatment decisions,
  o The range of possible outcomes, and
  o The currently incomplete knowledge regarding the influence of childhood treatment on outcome.
• For member’s pursuing reassignment, psychotherapy focuses on supporting the member before, during and after reassignment, as well as offering a safe place to explore identities and consider the transitioning experience (WPATH Guidelines, version 7, 2011; Olson, et al 2011).
  o This includes ascertaining eligibility and readiness for hormone and surgical therapy, or locating professionals capable of making these ascertainments to whom the member may be referred (APA Task Force on Gender Identity, 2012).
• Peer and support groups for members and caregivers should also be considered (APA Task Force on Gender Identity, 2012).
Behavioral health evaluation of readiness for hormone therapy and/or surgery:

- At least several months of participation in psychotherapy is recommended prior to initiating physical treatments that produce effects that are not fully reversible (APA Task Force on Gender Identity, 2012).
- Delaying therapy with hormones or surgery until serious mental health difficulties are addressed promotes adherence to needed psychiatric and other mental health treatment, such that the individual experiences benefit with regard to both the gender dysphoria and the concurrent psychiatric illness (APA Task Force on Gender Identity, 2012).
- Evaluation of readiness for hormone therapy (WPATH Guidelines, version 7, 2011):
  - Coordination of care among a client's overall care team is recommended.
  - The evaluating behavioral health provider should provide documentation – in patient’s chart and/or referral letter - of the patient's personal and treatment history, progress, and eligibility.
  - Behavioral health providers who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.
- Evaluation of readiness for surgery (WPATH Guidelines, version 7, 2011):
  - Coordination of care among a client's overall care team is recommended.
  - One behavioral health evaluation from a qualified behavioral health provider is needed for breast/chest surgery. The behavioral health provider should also be aware of additional criteria for breast/chest surgery, including:
    - Persistent, well-documented gender dysphoria;
    - Capacity to make a fully informed decision and to consent for treatment;
    - Age of majority – the age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention;
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Two behavioral health evaluations of readiness from qualified behavioral health providers who have independently assessed the patient are required for genital surgery. The behavioral health providers should also be aware of additional criteria for genital surgery, including:
    - Persistent, well-documented gender dysphoria;
    - Capacity to make a fully informed decision and to consent for treatment;
    - Age of majority – the age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention;
    - If significant medical or mental health concerns are present, they must be well controlled;
    - A minimum of 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual);
    - A minimum of 12 continuous months living in a gender role that is congruent with the patient's gender identity;
  - The evaluating behavioral health providers should provide documentation of the patient's personal and treatment history, progress, and eligibility.
  - Behavioral health providers should clearly document a patient's experience in the gender role in the patient's chart, including the start date of living full time for those who are preparing for genital surgery.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Description</th>
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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 the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.
<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity Psychiatry Services &amp; Procedures (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
</tr>
<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)</td>
</tr>
<tr>
<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td>H0015</td>
<td>Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education</td>
</tr>
<tr>
<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
</tr>
<tr>
<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
</tr>
<tr>
<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
</tr>
<tr>
<td>H2001</td>
<td>Rehabilitation program, per 1/2 day</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
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<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
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<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
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<tr>
<td>H2017</td>
<td>Psychosocial rehabilitation services, per 15 minutes</td>
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<tr>
<td>H2018</td>
<td>Psychosocial rehabilitation services, per diem</td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic behavioral services, per 15 minutes</td>
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<tr>
<td>H2020</td>
<td>Therapeutic behavioral services, per diem</td>
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<tr>
<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
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<tr>
<td>S0201</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
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<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
</tr>
<tr>
<td>S9482</td>
<td>Family stabilization services, per 15 minutes</td>
</tr>
<tr>
<td>S9484</td>
<td>Crisis intervention mental health services, per hour</td>
</tr>
<tr>
<td>S9485</td>
<td>Crisis intervention mental health services, per diem</td>
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### REFERENCES


### REVISION HISTORY

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<tr>
<td>5/10/2016</td>
<td>• Version 1 - Draft Approval by Behavioral Policy &amp; Analytics Committee</td>
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<tr>
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<td>• Version 2 - Changes to standard template approved by UM Committee</td>
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<tr>
<td>10/11/2016</td>
<td>• Version 2 - Changes to standard template approved by UM Committee</td>
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<tr>
<td>10/11/2017</td>
<td>• Version 3 – Annual Review</td>
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<td>• Version 4 – Annual Review</td>
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