



United Behavioral Health

Coverage Determination Guideline: Gender Dysphoria

Document Number: BH803GD012020

Effective Date: January 27, 2020

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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®¹.

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.

¹ Optum is a brand used by United Behavioral Health and its affiliates.

COVERAGE RATIONALE

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 provider² 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, 2012):
 - 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 assessment and diagnostic purposes;
 - Ability to identify and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria;
 - Documented supervised training and proficiency in psychotherapy or counseling;
 - Knowledgeable about gender-nonconforming identities and expressions, and the evaluation and treatment of gender dysphoria;
 - Continuing education in the assessment, diagnosis, and treatment of gender dysphoria;
 - Develop and continue cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients.

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

- Recommended minimum credentials for behavioral health providers working with children or adolescents with gender dysphoria (WPATH Guidelines, version 7, 2012):
 - Meet the competency requirements for behavioral health providers working with adults, as outlined above;
 - Trained in childhood and adolescent developmental psychopathology;
 - Proficient in evaluating, 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):
 - <http://www.psychiatry.org> > Psychiatrists > Practice > Clinical Practice Guidelines
- The gender dysphoria evaluation should include (WPATH Guidelines, version 7, 2012; APA Task Force on Gender Identity, 2012):
 - Acknowledging the member's concerns with a thorough assessment of the presenting dysphoria and any concurrent psychiatric illness;
 - Educating the member and family/support system about therapeutic options as well as their strengths, limitations or misperceptions;
 - Exploring the history, nature and characteristics of the member's gender identity in order to accurately diagnose the member;
 - Evaluating the member's emotional functioning, peer and other social relationships, school/occupational functioning, and the strengths and weaknesses of family functioning;
 - 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:
 - 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, 2012).
 - It is common for gender dysphoric children to have concomitant anxiety and depression disorders (WPATH Guidelines, version 7, 2012).
 - In children, nonconforming behaviors may or may not accompany persistent and severe discomfort with primary sex characteristics (WPATH Guidelines, version 7, 2012):
 - 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.
 - 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).
 - 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).
- Examples of assessment tools include the Utrecht Gender Dysphoria Scale and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (Shulman et al., 2017).
- A comprehensive evaluation should include the individual's past experiences with gender nonconformity, in addition to coping skills and sources of resilience (American Psychological Association, 2015).
- The diagnostic process should establish that the individual fulfills all DSM-5 diagnostic criteria for gender dysphoria and evaluates for concurrent psychiatric disturbance which may interfere with the treatment (Byne et al., 2018).
 - The provider should be aware that many transgender individuals face high rates of depressive, anxiety, and substance use disorders, as well as suicidality (Byne et al., 2018).

- Evaluation regarding history and the psychological consequences of gender-related stigma beginning in childhood is crucial due to the rising rates of violence experienced by this population (Byne et al., 2018).
- 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 (APA, 2013).
- Anxiety and depressive disorders in adolescents and adults are most common (APA, 2013).
- Providers should inquire about circumstances commonly encountered by individuals with sexual and gender minority status that present an 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 (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed.; DSM-5; APA, 2013):
 - Simple nonconformity to stereotypical gender role behavior;
 - 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;
 - 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;
 - 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 DSM:
 - Diagnosis of gender dysphoria 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., 2017).
 - 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).
 - 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).
 - Utilizing the term dysphoria rather than gender identity disorder denotes a clinical problem or distress; however, there is diverse usage of this term which continues to require clarity (Davy & Toze, 2018).

Treatment of individuals with gender dysphoria:

- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016): <http://www.psychiatry.org> > Psychiatrists > Practice > Clinical Practice Guidelines
- 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. Individuals that remain uncertain are recommended to participate in support groups including transgender peer-led groups, which can be useful in clarifying transitioning goals (Byne et al., 2018).
 - Treatment includes a component of age and developmentally appropriate psychoeducation provided to the member (APA Task Force on Gender Identity, 2012).
 - 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).
 - Research shows improved quality of life with individuals receiving supportive services such as psychotherapy and medical treatment (American Psychological Association, 2015).
 - Research shows that a multidisciplinary treatment approach is recommended for positive outcomes. Collaboration between primary health care, psychologists, and associated health disciplines should occur promptly (American Psychological Association, 2015).

- 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).
 - 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, 2012). This entails disclosure of (APA Task Force on Gender Identity, 2012):
 - The full range of treatment options available (including those that might conflict with the clinician's beliefs and values),
 - The limitations of the evidence-base that informs treatment decisions,
 - The range of possible outcomes, and
 - 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, 2012).
 - 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, 2012):
 - Coordination of care among a client's overall care team is recommended.
 - Hormone therapy can be initiated with a behavioral health evaluation of readiness from a qualified behavioral health provider.
 - 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, eligibility, and informed consent.
 - 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, 2012):
 - 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.

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 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.

Diagnosis Codes	Description
F64.0	Gender Dysphoria in Adolescents and Adults
F64.2	Gender Dysphoria in Children

Procedure Codes	Description
90785	Interactive complexity (list separately in addition to the code for primary psychiatric service/procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
G0177	Training and educational services related to the care and treatment of patient's

	disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes
H0015	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
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	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
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes
S0201	Partial hospitalization services, less than 24 hours, per diem
S9480	Intensive outpatient psychiatric services, per diem
S9482	Family stabilization services, per 15 minutes
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

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REVISION HISTORY

Date	Action/Description
05/03/2016	<ul style="list-style-type: none"> • Version 1 - Draft
5/10/2016	<ul style="list-style-type: none"> • Version 1 – Draft Approval by Behavioral Policy & Analytics Committee
07/12/2016	<ul style="list-style-type: none"> • Version 2 – Changes to standard template approved by UM Committee
10/11/2016	<ul style="list-style-type: none"> • Version 2 – Changes to standard template approved by UM Committee
10/11/2017	<ul style="list-style-type: none"> • Version 3 – Annual Review
02/12/2019	<ul style="list-style-type: none"> • Version 4 – Annual Review
01/27/2020	<ul style="list-style-type: none"> • Version 5 – Annual Review