NO. 91622-R4

GENDER DYSPHORIA, NON-SURGICAL TREATMENT

Effective date: 12/01/2025 **Last reviewed**: 11/2025

Instruction for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Related policies:

- Gender Affirming Surgery No. 91612

I. MEDICAL NECESSITY CRITERIA

Determination of the medical necessity of surgical, non-surgical, and/or related services for the treatment of gender dysphoria is independent of the determination of whether the treatment is a covered benefit. Coverage for services varies across plans and is defined in benefit or plan documents. For coverage details, including exclusions or limitations, refer to member specific plan documents. Coverage for services may also be governed by state and/or federal law, mandates, or other regulatory rules.

For government sponsored programs and plans see plan documents for age minimum and/or other limitations.

A. The following non-surgical services are considered medically necessary for gender incongruence/dysphoria; limitations may apply:

1. Mental health services as defined in plan coverage documents and policies.
2. Hormone therapy when all of the following criteria are met:

a. Diagnosis of gender incongruence/dysphoria made by a licensed practitioner with expertise in gender dysphoria, incongruence and diversity.
b. Optimal management of any comorbid medical or mental health conditions.
c. Member (or parent/guardian) has the capacity to make fully informed decisions and consent/assent to treatment.
d. Laboratory testing to monitor hormone therapy is a covered benefit.
e. Member's contract must include a prescription drug rider.
f. Prior authorization may be required for certain pharmaceuticals.

Note: Hormone therapy obtained from a pharmacy is subject to the pharmaceutical cost share/copay of the member's contract. Implanted hormone therapy is covered at the medical benefit level.

3. Hormonal suppression of puberty is considered medically necessary when all of the following are met:

a. All of the criteria for hormone therapy.
b. Onset of puberty to at least Tanner Stage 2.
c. Gender diversity or gender incongruence / dysphoria (whether suppressed or expressed) is marked and sustained over time.

Evidence demonstrating gender diversity/incongruence sustained over time can be provided via history obtained directly from the adolescent and parents/caregivers when this information is not documented in the medical records.

d. Gender incongruence/ dysphoria worsened with the onset of puberty.
e. Except in the case of an emancipated minor, parent(s) or guardian(s) consent(s) to treatment, and is(are) involved and supportive in the treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

B. Non-surgical services for gender incongruence / dysphoria are limited to coverage as defined in Section I.A above. All other services are not considered medically necessary, including but are not limited to the following:

1. Cosmetic items and services (e.g., cosmetics, hair removal, wigs)

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	None identified
First Coast Service Options, Inc.	None identified
National Government Services, Inc.	None identified
Noridian Healthcare Solutions	None identified
Novitas Solutions, Inc.	None identified
Palmetto GBA	None identified
WPS Insurance Corporation	None identified

III. BACKGROUND

Gender incongruence/ dysphoria focuses on a person's experienced identity and any need for gender-affirming medical and/or surgical treatments (GAMSTs) to better align their body with their gender identity. Many transgender and gender diverse (TGD) people will not require therapy or other forms of mental health care as part of their transition, while others may benefit from the support of mental health providers and systems.

Hormone replacement therapy (HRT) plays a role in the gender transition process whereby individuals assigned male at birth (AMAB) are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. The Endocrine Society guidelines include estrogens in combination with androgen-lowering medications (Hembree et al, 2017). Possible side effects should be discussed with patients, particularly those at risk for venous thromboembolism (T'Sjoen, 2019). Individuals assigned female at birth (AFAB) are treated with testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. The Endocrine Society guidelines for transgender men include testosterone therapy for virilization with deepening of the voice, cessation of menses, and increases of muscle mass and facial and body hair. (T'Sjoen, 2019). HRT may be effective in reducing the adverse psychologic impact of gender incongruence/dysphoria.

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood. These processes do not all begin and end at the same time for a given individual, nor do they occur at the same age for all persons. Therefore, the lower and upper borders of adolescence are imprecise and cannot be defined exclusively by age. The understanding of gender identity development in adolescence is continuing to evolve. When providing clinical care to gender diverse young people and their families, it is important to know what is and is not known about gender identity during development. When considering treatments, families

may have questions regarding the development of their adolescent's gender identity, and whether or not their adolescent's declared gender will remain the same over time. A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical and surgical treatments (GAMSTs). Given the lifelong implications of medical treatment and the young age at which treatments may be started, adolescents, their parents, and care providers should be informed about the nature of the evidence base. Recently published longitudinal studies followed and evaluated participants at different ages and stages of their gender-affirming treatments. In these studies, some participants may not have started gender-affirming medical treatments, some had been treated with puberty suppression, while still others had started gender-affirming hormones or had even undergone gender-affirming surgery (GAS) (Achille et al., 2020; Allen et al., 2019; Becker-Hebly et al., 2021; Kuper et al., 2020, Tordoff et al., 2022). The use of puberty-blocking medications, such as GnRH analogues, is not recommended until children have achieved a minimum of Tanner stage 2 of puberty because the experience of physical puberty may be critical for further gender identity development for some TGD adolescents (Steensma et al., 2011). Tanner staging refers to five stages of pubertal development ranging from prepubertal (Tanner stage 1) to post-pubertal, and adult sexual maturity (Tanner stage 5) (Marshall & Tanner, 1969). For assigned females at birth, pubertal onset (e.g., gonadarche) is defined by the occurrence of breast budding (Tanner stage 2), and for birth-assigned males, the achievement of a testicular volume of greater than or equal to 4 mL (Roberts & Kaiser, 2020).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
World Professional Association for Transgender Health (WPATH)	Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (September 15, 2022)
United States Professional Association for Transgender Health	No guidelines
Endocrine Society	Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (September 2017)
American Psychological Association	Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (December 2015)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration: Drugs for the most current information.

VI. CODING

ICD-10 Codes that may support medical necessity

F64.0 Gender identity disorder in adolescence and adulthood
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

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

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Past review dates: 08/2018, 08/2019, 08/2020, 08/2021, 08/2022, 11/2022, 11/2023, 11/2024

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