

Subject: Gender Affirming Treatment for Children and Adolescents (17 yrs. and under)

Medical Policy #: 7.31

Original Effective Date: 09-28-2022

Status: Reviewed

Last Annual Review Date: 03-20-2024

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans, or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Commercial Plans: Refer to your benefit description and considerations section as member specific benefit plan language may vary. Some policies include benefit details under cosmetic procedures.

Description

This Medical Policy covers topics related to the treatment of gender affirming care for children and adolescents 17 years of age and younger who have a Tanner Stage II or above. This includes voice and hormonal therapy.

Transgender and gender diverse individuals may seek one or multiple forms of gender affirmation. The age of the patient and effect on fertility may be determined by government regulation that may or may not supersede benefit or plan offering.

For individuals who identify as transgender or gender diverse and seek gender affirming care a referral from the treating provider to care coordination and behavioral health services is considered standard of care.

MPM 7.3 Gender Affirming Treatment and Surgery (Adult, 18 years of age and older) may be applicable for selected surgical procedures starting at age 18.

For hormone therapy for Gender Affirming Treatment in Children and Adolescents please refer to the PHP pharmacy policy.

Coverage Determination

Prior Authorization is required for medication. Logon to Pres Online to submit a request:

<https://ds.phs.org/preslogin/index.jsp>

Coverage is for Medicaid, Medicare, and Commercial.

- I. Primary care, specialty care and multi-disciplinary clinical care for gender affirming services are a covered benefit for all ages. **These do not require a prior authorization.**
- II. Gender affirming surgery for children & adolescents who identify as transgender or gender diverse is not a covered benefit for those 17 years of age and under (refer to MPM 7.3 Gender Affirming Treatment and Surgery, Adult 18 years of Age and Older).
- III. Gender affirming hormone therapy in children and adolescents, including medically and developmentally appropriate pubertal blockade, feminizing hormone therapy, and masculinizing hormone therapy, is a covered benefit. Please refer to the [PHP pharmacy policy](#) for details.
Prior Authorization is required.
- IV. Voice therapy and Voice lessons (12 sessions) per 12-month period.

Prior authorization is not required for 92507 and 92508.

Coding

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

CPT codes	Description
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

Covered ICD-10 Codes	Description
F64.2	Gender identity disorder of childhood

Reviewed by / Approval Signatures

Population Health & Clinical Quality Committee: Clinton White, MD

Medical Director: Jim Romero, MD

Date Approved: 12-11-2024

References

1. [Standards of Care for the Health of Transgender and Gender Diverse People, Version 8](#). The World Professional Association for Transgender Health (WPATH) for Transgender Health, published only: 15 Sep 2022. [Accessed 01/05/2024]
2. Multiple Medical Policies Medicare National Coverage Determinations Manual, Chapter 1, Part 2 (Sections 90 – 160.26). Gender reassignment Surgery for Gender Dysphoria, 140.9, A-D, Implemented 04/04/2017. [Cited 01/05/2024]
3. Palmetto GBA, Gender Reassignment Services for Gender Dysphoria (A53793), not in New Mexico region. Revision date: 01/01/2023, R#14 (not an LCD reference article). Accessed 01/05/2024
4. CMS National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9), V1 Pub# 100-3, Effective Date: 08-30-2016. [01/05/2024]
5. Aetna, Gender Reassignment Surgery, Number:0615, Effective: 05/14/2002, Last reviewed: 11/27/2023, Next Review: 07/11/2024, Accessed 01/05/2024.
6. [New Mexico, OSI](#), Bulletin 2018-013, Transgender non-discrimination in Health Insurance Benefits, August 23, 2018. [01/05/2024]
7. Hayes, Sex Reassignment Surgery for The Treatment of Gender Dysphoria, Health Technology Assessment, Aug 01/ 2018, Annual Review: July 27, 2022. [Cited 01/05/2024]
8. MCG Health Ambulatory Care 27th Edition, Gonadotropin-Releasing Hormone (GnRH) Agonists (ACG: A-0304 AC), Last Update: 09-21-2023. [Cited 01/05/2024]
9. Plastic and Reconstructive Surgery - [Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence](#)- Global Open: March 2021 - Volume 9 - Issue 3 - p e3477, doi: 10.1097/GOX.00000000000003477; Published online 19 March 2021. [Cited 01/05/2024]
10. Hayes, Hormone Therapy for the Treatment of Gender Dysphoria, Health Technology Assessment, May 19, 2014, Annual review: Aug 29, 2018 [Cited 01/05/2024].
11. Hayes, Female-to-Male Gender-Affirming Surgical Procedures for Adolescents With Gender Dysphoria, Evolving Evidence Review May 23,2023. [Cited 01/05/2024]
12. NMAC LOD #22 Gender Affirming Healthcare Medications and Procedures, Effective 10/01/2024, [Cited 10/14/2024]
13. PHP Senior Program Manager-Community Health ABQ, Lilan Metzler.

Publication History

09-28-2022 Original effective date. PHP Medical policy Committee reviewed on 09-16-2022. Policy created to confirm with the adolescent population. Policy is for 17 y/o and under only.

Update only on 11-16-2022. Annual review date will remain as 09-28-2022. PHP Medical policy

Not every Presbyterian health plan contains the same benefits. Please refer to the member's specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].

Committee reviewed on 11-02-2022. The description section changed from “When a diagnosis of gender dysphoria is identified a referral to care coordination and behavioral health services is considered standard when applicable” to “When a diagnosis of gender dysphoria is identified a referral from the treating provider to care coordination and behavioral health services is considered standard of care.” Coverage indication language for non-surgical treatment was added to cover voice therapy and voice lessons (92507 and 92508). Prior will not be required for 92507 and 92508. Removed “initial or continuous” from hormone therapy statement. Removed the Exclusion statement.

Update to policy: PHP Medical policy Committee reviewed on 05-24-2023. Minor language changes throughout policy to conform with appropriate standard language as well as HSD. No change to criteria. Added additional ICD-10, (F64.2).

09-27-2023 **Update on July 2023:** Update Disclaimer section of policy to include FEHB
PHP Medical policy Committee reviewed on 09-08-2023. No change. The policy will be moved to be reviewed with MPM 7.3 in March for CY 2024.

03-20-2024 Annual review. PHP Medical policy Committee reviewed on 01/05/2024. There is no change in coverage on this revision. The criteria will continue with WPATH SOC8 for pediatric and adolescent endocrinology recommendations for hormone treatment. Voice therapy will continue to be covered without PA requirement.

10/14/2024 Ad Hoc: Effective 10/1/2024. Policy updated with the following: Language changes have adjusted to reflect appropriate coverage per NMAC LOD #22. Requirements for mental health diagnoses to verify gender dysphoria have been removed. Removed all language under Appendix A (DSM 5 criteria) & Appendix B (Minimum Credentials for a Qualified Mental Health Professional). Added language “Gender affirming hormone therapy in children and adolescents, including medically and developmentally appropriate pubertal blockade, feminizing hormone therapy, and masculinizing hormone therapy, is a covered benefit”. PHP pharmacy will continue to manage hormone therapy and prior authorization. Removed ICD-10: F64.0, F64.1, F64.8, F64.9 and Z87.890.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: [Click here for Medical Policies](#)

Web links:

At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.