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# PHYSICIAN SERVICES PUBLIC WORKSHOP October 3 , 2017



**Proposed Language for the Nevada Medicaid  
Services Manual (MSM) – Chapter 600,  
Physician Services ~ *Draft***



## Section 603.10 Physician Services in Outpatient Setting

### Propose deletion of language in section:

**(F)** Ambulatory Centers (ASC) Facility and Non-Facility Based; **(3)** Surgical procedures deemed experimental, not well established or not approved by Medicare or Medicaid are not covered and will not be reimbursed for payment. Below is a list of definitive non-covered services.

- ~~k. Transsexual surgery, also known as sex reassignment surgery or intersex surgery and all ancillary services including the use of pharmaceuticals;~~



# 607 TRANSGENDER SERVICES

## Physician's Services

### Description

Transgender Services include treatment for gender dysphoria (GD), formerly known as gender identity disorder (GID). Treatment of GD is a DHCFP covered benefit, including both hormonal and surgical modalities, and psychotherapy, based on medical necessity. Genital reconstruction surgery (GRS) describes a number of surgical procedure options for the treatment of GD.



# 607 TRANSGENDER SERVICES

## Physician's Services

### Description cont.

According to the World Professional Association for Transgender Health (WPATH), the organization that promotes the standards of health care for transsexual, transgender, and gender nonconforming individuals, through the articulation of Standards of Care (SOC), gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### Coverage and Limitations

#### A. Hormone Therapy

1. Hormone therapy is covered for treatment of gender dysphoria based on medical necessity.
  - a. Estrogen and testosterone drugs are covered with no prior authorization, based on medical necessity for treatment of gender dysphoria.



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### Hormone Therapy cont.

- b. Treatment with gonadotropin-releasing hormone (GnRH) analogs for delaying the onset of puberty and/or continued pubertal development should be initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, and no earlier than Tanner Stages 2-3. Prior to initiation of puberty suppression therapy, adolescents must fulfill eligibility and readiness criteria and must have a comprehensive mental health evaluation. Ongoing psychological care is required for continued puberty suppression therapy.



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### Hormone Therapy cont.

- c. Hormone therapy is covered for treatment of adolescents and adults diagnosed with gender dysphoria and meet appropriate eligibility and readiness criteria. To qualify for hormone therapy, the recipient must have:
1. persistent and well-documented case of gender dysphoria; and
  2. capacity to make a fully informed decision and give consent for treatment; and
  3. significant medical or mental health concerns reasonably well controlled; and





# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### Hormone Therapy cont.

4. Comprehensive mental health evaluation provided in accordance with Version 7 of the WPATH SOC.
- d. The aforementioned conditions in 1 - 4 above must be well documented in the recipient's medical record by a medical provider working within the scope of their license.



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### B. Genital Reconstruction Surgery

1. Genital reconstruction surgery (GRS) is covered for recipients that are sufficiently physically fit and meet eligibility criteria under Nevada and federal laws.
2. Prior authorization is required for all gender reconstruction surgery procedures.
3. To qualify for surgery, the recipient must be 18 years of age or older.
4. The recipient must obtain authentic letters from two qualified licensed health care professionals who have independently assessed the recipient and are referring the recipient for surgery.



## 607.1 COVERAGE AND LIMITATIONS

### Transgender Services

#### **B. Genital Reconstruction Surgery cont.**

The two letters must be authenticated and signed by:

- a. A licensed psychiatrist or psychologist that the recipient has an established and ongoing relationship; and
- b. A licensed psychiatrist, psychologist, or physician, working within the scope of their license, that has only had an evaluation role with the recipient.
- c. Together, the letters must establish the recipient has:



## 607.1 COVERAGE AND LIMITATIONS

### Transgender Services

#### **B. Genital Reconstruction Surgery cont.**

1. a persistent and well-documented case of gender dysphoria;
2. received hormone therapy appropriate to the recipient's gender goals, which shall be for a minimum of 12 months in the case of a recipient seeking genital surgery, unless such therapy is medically contraindicated or the recipient is otherwise unable to take hormones;



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### B. Genital Reconstruction Surgery cont.

3. lived for 12 months in a gender role congruent with the recipient's gender identity, and has received mental health counseling, as deemed medically necessary during that time;
4. significant medical or mental health concerns reasonably well-controlled; and
5. the capacity to make a fully informed decision and consent to the treatment.



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### Gender Reassignment Surgery cont.

5. Augmentation mammoplasty for male-to-female (MTF) recipients is a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy.
6. Electrolysis is only included for surgical site electrolysis as part of pre-surgical preparation for chest or genital surgical procedures. Electrolysis is not covered for facial or other cosmetic procedures or as pre-surgical preparation for a surgical procedure not covered.



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### Gender Reassignment Surgery cont.

7. All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization. Please reference MSM Chapter 600, Section 603.4B for information concerning sterilization services.



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### C. Mental Health Therapy

1. Mental health therapy is covered for treatment of gender dysphoria.
  - a. Please reference MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services, for coverage of mental health services and prior authorization requirements.





# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### D. Non-Covered Services

1. Payment will not be made for the following services and procedures:
  - a. cryopreservation, storage, and thawing of reproductive tissue, and all related services and costs;
  - b. reversal of genital and/or breast surgery;
  - c. reversal of surgery to revise secondary sex characteristics;
  - d. reversal of any procedure resulting in sterilization;
  - e. cosmetic surgery, and procedures including:



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### D. Non-Covered Services cont.

1. neck tightening or removal of redundant skin;
2. breast, brow, face, or forehead lifts;
3. chondrolaryngoplasty (commonly known as tracheal shave);
4. electrolysis, unless required for vaginoplasty;
5. facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
6. calf, cheek, chin, nose, or pectoral implants;
7. collagen injections;
8. drugs to promote hair growth or loss;



# 607.1 COVERAGE AND LIMITATIONS

## Transgender Services

### D. Non-Covered Services cont.

9. hair transplantation;
10. lip reduction or enhancement;
11. liposuction
12. thyroid chondroplasty; and
13. voice therapy, voice lessons, or voice modification surgery.



# Questions or Comments?

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