In the Matter of the Appeal of

[Redacted]

from a determination by the New York City Department of Social Services

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on June 8, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[Redacted]

For the Social Services Agency

Agency appearance waived by the Office of Administrative Hearings

For the Managed Long-Term Care Plan

David Miller, Esq., HealthFirst Attorney

ISSUE

Was the Managed Long-Term Care Plan’s determination to deny the Appellant's prior approval request, correct?
FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant (age 26) has been in receipt of Medical Assistance authorization through a Medicaid Managed Care Plan, HealthFirst.

2. On March 1, 2017, the Plan denied the Appellant's request for Reduction Mammaplasty because “You did not live 12 months as the congruent gender, did not have hormone therapy for the stated period of time or state was contraindicated and have no plan for transition. In addition, there are inconsistencies in the documentation regarding your diagnosis. You have a letter from your psychiatrist stating that you were diagnosed with gender dysphoria. However, this is not supported by the second clinician letter.”

3. On April 6, 2017, the Appellant requested this fair hearing. The hearing was held on June 8, 2017, and a Decision After Fair Hearing (Decision) affirming HealthFirst’s (Plan) determination was issued on June 14, 2017. Subsequently, the Appellant’s representative requested reconsideration of the Decision claiming that affirming the Plan’s determination on the grounds “that there was insufficient evidence at the hearing to establish that the requested procedure is in fact medically necessary and not cosmetic,” was inappropriate, given the evidence presented at the hearing. The Office of Administrative Hearings reviewed the fair hearing record and determined that the Decision is not supported by the evidence presented at the hearing. Accordingly, the June 14, 2017 Decision has been vacated and this Amended Decision is substituted therefor.

APPLICABLE LAW

Social Services Law section 365-a(2) states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant
handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment.

A Medicaid managed care plan is required to authorize and pay for medically necessary treatments and services within the Medicaid benefit package for members. Pursuant to Section 16.2 of the Medicaid and Family Health Plus Managed Care Model Contract between a provider and the New York State Department of Health, a Medicaid managed care plan must adopt practice guidelines consistent with current standards of care for making determinations of medical necessity.

The Medicaid Managed Care Model Contract delineates the terms by which Medicaid Managed Care Plans agree to cover specified healthcare services in accordance with New York State Medicaid Guidelines. Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.
Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap.

18 NYCRR 513.1 provides the following definition of medical necessity:

(c) Necessary to prevent, diagnose, correct or cure a condition means that requested medical, dental and remedial care, services or supplies would: meet the recipient's medical needs; reduce the recipient's physical or mental disability; restore the recipient to his or her best possible functional level; or improve the recipient's capacity for normal activity. Necessity to prevent, diagnose, correct or cure a condition must be determined in light of the recipient's specific circumstances and the recipient's functional capacity to use or make use of the requested care, services or supplies and appropriate alternatives.

Section 364-j (1)(c) of the Social Services Law defines "Managed Care Program" as a program in a social services district in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly or indirectly (including by referral) from a managed care provider ("Medicaid Managed Care Health Plan"), or, if applicable, a mental health special needs plan or a comprehensive HIV special needs plan.

18 NYCRR section 505.2 explains that the Medical Assistance Program includes physicians’ services, as there defined.

18 NYCRR Section 505.2(l) provides, as amended in December 2016:

(l) Gender dysphoria treatment.
(1) As provided in this subdivision, payment is available for medically necessary hormone therapy and/or gender reassignment surgery for the treatment of gender dysphoria.
(2)
(i) Hormone therapy, whether or not in preparation for gender reassignment surgery, shall be covered as follows:
(a) treatment with gonadotropin-releasing hormone agents (pubertal suppressants), based upon a determination by a qualified medical professional that an individual is eligible and ready for such treatment, i.e., that the individual:
(1) meets the criteria for a diagnosis of gender dysphoria;
(2) has experienced puberty to at least tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria;
(3) does not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment;
(4) has adequate psychological and social support during treatment; and
(5) demonstrates knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment;
(b) treatment with cross-sex hormones for patients who are 16 years of age and older, based upon a determination of medical necessity made by a qualified medical professional; patients who are under 18 years of age must meet the applicable criteria set forth in clause (a) of this subparagraph.
(ii) Notwithstanding the requirement in clause (i)(b) of this paragraph that an individual be 16 years of age or older, payment for cross-sex hormones for patients under 16 years of age who otherwise meet the requirements of clause (i)(b) of this paragraph shall be made in specific cases if medical necessity is demonstrated and prior approval is received.
(3) (i) Gender reassignment surgery shall be covered for an individual who is 18 years of age or older and has letters from two qualified New York State licensed health professionals who have independently assessed the individual and are referring the individual for the surgery. One of these letters must be from a psychiatrist, psychologist, psychiatric nurse practitioner, or licensed clinical social worker with whom the individual has an established and ongoing relationship. The other letter may be from a psychiatrist, psychologist, physician, psychiatric nurse practitioner, or licensed clinical social worker acting within the scope of his or her practice, who has only had an evaluative role with the individual. Together, the letters must establish that the individual:
   (a) has a persistent and well-documented case of gender dysphoria;
   (b) has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless such therapy is medically contraindicated or the individual is otherwise unable to take hormones;
   (c) has lived for 12 months in a gender role congruent with the individual’s gender identity, and has received mental health counseling, as deemed medically necessary, during that time;
   (d) has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well-controlled prior to the gender reassignment surgery; and
   (e) has the capacity to make a fully informed decision and to consent to the treatment.
   (ii) Notwithstanding subparagraph (i) of this paragraph, payment for gender reassignment surgery, services, and procedures for patients under 18 years of age may be made in specific cases if medical necessity is demonstrated and prior approval is received.
(4) For individuals meeting the requirements of paragraph (3) of this subdivision, Medicaid coverage will be available for the following gender reassignment surgeries, services, and procedures, based upon a determination of medical necessity made by a qualified medical professional:
   (i) mastectomy, hysterectomy, salpingectomy, oophorectomy, vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, penectomy, orchietomy, vaginoplasty, labiaplasty, clitoroplasty, and/or placement of a testicular prosthesis and penile prosthesis;
(ii) breast augmentation, provided that: the patient has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones; (iii) electrolysis when required for vaginoplasty or phalloplasty; and (iv) such other surgeries, services, and procedures as may be specified by the department in billing guidance to providers.

(5) For individuals meeting the requirements of paragraph (3) of this subdivision, surgeries, services, and procedures in connection with gender reassignment not specified in paragraph (4) of this subdivision, or to be performed in situations other than those described in such paragraph, including those done to change the patient’s physical appearance to more closely conform secondary sex characteristics to those of the patient’s identified gender, shall be covered if it is demonstrated that such surgery, service, or procedure is medically necessary to treat a particular patient’s gender dysphoria, and prior approval is received. Coverage is not available for surgeries, services, or procedures that are purely cosmetic, i.e., that enhance a patient’s appearance but are not medically necessary to treat the patient’s underlying gender dysphoria.

(6) All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization.

Section 358-5.9(a) of the Regulations provide that at a fair hearing concerning the denial of an application for or the adequacy of medical assistance or services, the Appellant must establish that the Agency's denial of assistance was not correct or that the appellant is eligible for a greater amount of assistance.

*Medicaid Physician Procedure Codes, Physician - Procedure Codes, Section 5 – Surgery (2017) reads in part:

**INTERSEX SURGERY GENDER REASSIGNMENT SURGERY**

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When performing the following procedures for the purpose of gender reassignment, physicians must obtain and maintain in their records copies of the two letters from New York State licensed health practitioners recommending the patient for surgery (see June 2015 Medicaid Update). These procedures, when medically necessary, do not require prior approval or paper claim submission:

19303: Mastectomy, simple, complete

19304: Mastectomy, subcutaneous

19324: Mammaplasty, augmentation; without prosthetic implant

19325: with prosthetic implant

For male-to-female gender reassignment, augmentation mammoplasty may be considered
medically necessary for individuals with a diagnosis of gender dysphoria when that individual does not have any breast growth after 24 months of cross-sex hormone therapy, or in instances where hormone therapy is medically contraindicated.

The June 2015 Medicaid Update provided guidance regarding Medicaid policy on the treatment of gender dysphoria.

The January 2017 Medicaid Update provided further guidance regarding Medicaid policy on the treatment of gender dysphoria and stated in pertinent part as follows:

Transgender Related Care and Services Update

This article updates the June 2015 Medicaid Update article titled, "New York State Medicaid Updates Regulations" and the May 2016 Medicaid Update article titled, "Transgender Related Care and Services Update."

Medicaid regulations at 18 NYCRR 505.2(l), relating to Medicaid coverage for transgender care and services, were amended on August 31, 2016 and again on December 7, 2016.

Gender Reassignment Surgery

1. One of the prerequisites for Medicaid coverage of gender reassignment surgery is that the individual has letters from two qualified New York State licensed health professionals who have independently assessed the individual and are referring the individual for surgery. One letter must be written by a New York State licensed psychiatrist, psychologist, psychiatric nurse practitioner, or licensed clinical social worker who has an ongoing relationship with the patient. (The December 7, 2016 amendment to the regulation added licensed clinical social workers to this list.) The second letter may be written by a New York State licensed psychiatrist, psychologist, physician, psychiatric nurse practitioner, or licensed clinical social worker working within their scope of practice. The recommendation for surgery in each letter must be based on an independent assessment/evaluation of the individual.

2. The revised regulations provide that the following gender reassignment surgeries, services, and procedures are available, based on a determination of medical necessity by a qualified medical professional:
   - mastectomy, hysterectomy, salpingectomy, oophorectomy, vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, penectomy, orchiectomy, vaginoplasty, labiaplasty, clitoroplasty, and/or placement of a testicular prosthesis and penile prosthesis;
   - breast augmentation, provided that: the individual has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones; and
   - electrolysis when required for vaginoplasty or phalloplasty.
The above services are available under fee-for-service (FFS) Medicaid without prior approval. With respect to Medicaid Managed Care (MMC) enrollees, administrative prior authorization requirements may be applied; however, the MMC Plan must accept the qualified medical professional's determination of medical necessity. Any other surgeries, services, and procedures in connection with gender reassignment not listed above, or to be performed in situations not described above, including those done to change the patient's physical appearance to more closely conform secondary sex characteristics to those of the patient's identified gender, will be covered if it is demonstrated that such surgery, service, or procedure is medically necessary to treat a particular patient's gender dysphoria, and prior approval is received. Coverage is not available for surgeries, services, or procedures that are purely cosmetic, i.e., that enhance a patient's appearance but are not medically necessary to treat the patient's underlying gender dysphoria.

3. Although the minimum age for Medicaid coverage of gender reassignment surgery is generally 18 years of age, the revised regulations allow for coverage for individuals under 18 in specific cases if medical necessity is demonstrated and prior approval is received.

For complete billing guidance for gender reassignment surgery, please see the Physician-Surgery Provider Manual at: https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect5.pdf.

**DISCUSSION**

The record of the hearing reveals that HealthFirst determined the Appellant's request for reduction mammoplasty was not medically necessary and denied the Appellant's request for the following reasons:

1. “You did not live 12 months as the congruent gender, did not have hormone therapy for the stated period of time or state was contraindicated and have no plan for transition.”
2. “In addition, there are inconsistencies in the documentation regarding your diagnosis. You have a letter from your psychiatrist stating that you were diagnosed with gender dysphoria. However, this is not supported by the second clinician letter.”
3. “You have asked for reduction mammoplasty (removal of breast tissue). This is denied as not medically necessary as it does not meet HealthFirst criteria. The data provided did not show that:
   - You have a well written case of gender identity dysphoria (when one identifies with the sex they were not born with);
   - You have taken hormone therapy appropriate for your gender goals for a minimum of 12 months or why you are not able to take hormone therapy,
   - You have lived in a role that is your gender identity for 12 months.”
In accordance with 18 NYCRR 505.2(l)(4), for individuals meeting the requirements of 18 NYCRR 505.2(l)(3), Medicaid coverage will be available for certain gender reassignment surgeries, services, and procedures referenced in 18 NYCRR 505.2(l)(4), based upon a determination of medical necessity made by a qualified medical professional. At the above-referenced fair hearing, HealthFirst presented four (4) letters submitted to HealthFirst by the Appellant's medical providers to support the medical necessity of a reduction mammoplasty. Together the letters established that:

(i) the Appellant has a persistent and well-documented case of gender dysphoria, and that the Appellant identifies as non-binary or gender non-conforming, meaning that the Appellant does not identify as either male or female, thereby satisfying 18 NYCRR 505.2(l)(3)(i)(a);

(ii) hormone therapy is medically contraindicated and not medically advisable in the Appellant's clinical setting and not consistent with the Appellant's treatment goals, because the Appellant identifies as non-binary and does not wish to take hormones,

(iii) fully transition, or undergo genital surgery, thereby satisfying 18 NYCRR

(iv) the Appellant has lived for more than 12 months in a gender role congruent with the Appellant's gender identity as non-binary, and has been in mental health treatment for two years with individual therapy weekly, thereby satisfying 18 NYCRR the Appellant is emotionally stable with no acute mental health concerns and in good health, thereby satisfying 18 NYCRR 505.2(l)(3)(i)(d); and

(v) the Appellant has the capacity to make a fully informed decision and to consent to the treatment, and has been informed of and understands the risks and benefits regarding surgery, thereby satisfying 18 NYCRR 505.2(l)(3)(i)(e).

As such, the Appellant's request met the requirements of 18 NYCRR 505.2(l)(3) and HealthFirst should have approved coverage for a reduction mammoplasty in accordance with 18 NYCRR 505.2(l)(4)(i), based upon the determinations of medical necessity made by the Appellant's qualified medical providers.

The HealthFirst denial is incorrect and incorrectly interprets 18 NYCRR 505.2(l). The following addresses each of the HealthFirst denial points.

The letters establish that the Appellant has lived for more than 12 months in a gender role congruent with the Appellant's gender identity as non-binary. The letters established hormone therapy is medically contraindicated and not medically advisable in the Appellant's clinical setting as it is not consistent with Appellant's treatment goals given the Appellant identifies as
non-binary, and does not wish to take hormones, fully transition, or undergo genital surgery. The regulation requires documentation establishing "hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless such therapy is medically contraindicated or the individual is otherwise unable to take hormones" (emphasis added). In this case, hormone therapy is not appropriate to the Appellant's individual gender goals, the Appellant is not seeking genital surgery and, as such, hormone therapy is medically contraindicated. The letters support that hormone therapy is not an advisable treatment.

The letters fully established that the Appellant has a persistent and well-documented case of gender dysphoria, and that the Appellant identifies as non-binary or gender nonconforming, meaning the Appellant does not identify as either male or female. To confirm, the January 30, 2017 letter from [redacted], M.D., cites the diagnosis codes consistent with those for gender dysphoria in adolescents and adults as specified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the other practitioner letters establish that the Appellant has a persistent and well-documented case of gender dysphoria.

The letters fully established that the Appellant has a persistent and well-documented case of gender dysphoria, and that the Appellant identifies as non-binary or gender nonconforming, meaning the Appellant does not identify as either male or female. HealthFirst appears asserted that a diagnosis of gender dysphoria requires the individual to conform to the gender opposite the gender assigned at birth. Requiring conformance to the opposite gender is inconsistent with the diagnosis of gender dysphoria as specified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which specifically provides that individuals with diagnosed with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as "natal gender") and their experienced or expressed gender, and experience stress about this incongruence. Experienced gender may include non-binary gender identity. Therefore, the distress associated with gender dysphoria is not limited to a desire to just be of the opposite gender, but may include a desire to be non-binary. The evidence establishes that the Appellant has lived for more than 12 months in a gender role congruent with the Appellant's gender identity as non-binary.

The Department's regulation at 18 NYCRR 505.2(l) provides Medicaid coverage of transgender care and services when such care and services are medically necessary to treat the individual's gender dysphoria. In this case, the record establishes that a [redacted] is medically necessary to treat the Appellant's gender dysphoria and should have been approved in accordance with 18 NYCRR 505.2(l).

While 18 NYCRR 5052(l)(4)(i) references "mastectomy", the Department's regulation should not be read to require the Appellant to seek or undergo a full mastectomy when seeking surgery to remove breast tissue if a mastectomy is not consistent with the Appellant's treatment plan. Based on the facts and circumstances of this case, the Appellant is entitled to pursue a lesser form of mastectomy, reduction mammoplasty, and is not required to undergo more extensive or extreme surgical intervention that has not been deemed medically appropriate to treat the Appellant's gender dysphoria. The record establishes that a bilateral reduction
mammoplasty with chest reconstruction is medically necessary to treat the Appellant's gender dysphoria and should have been approved in accordance with 18 NYCRR 505.2(f)(4)(i).

It is noted that the Administrative Law Judge who conducted the hearing submitted a recommended decision under which the HealthFirst decision was affirmed. However, for reasons described above, the Commissioner's designee has not adopted such recommendation, and this Decision has been issued in its stead.

**DECISION AND ORDER**

HealthFirst’s March 1, 2017 determination to deny the Appellant's prior approval request was not correct and is reversed.

1. HealthFirst is directed to approve the Appellant's request for Reduction Mammaplasty.

   Should HealthFirst need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to HealthFirst promptly to facilitate such compliance.

   As required by 18 NYCRR 358-6.4, HealthFirst must comply immediately with the directives set forth above.

DATED: Albany, New York
       05/11/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee