

**New York State Department of Health
Office of Health Insurance Programs
Criteria Standards for the Authorization and Utilization Management
of Hormone Therapy and Surgery for the Treatment of Gender Dysphoria**

Effective September 1, 2018, mainstream Medicaid Managed Care plans', HIV Special Needs Plans' and Health and Recovery Plans' (MMCPs) policies, procedures and coverage criteria for the authorization and utilization management of hormone therapy and surgery for the treatment of gender dysphoria under 18 NYCRR 505.2(l) must comply with the following standards. Such policies, procedures and coverage criteria must be submitted to and approved by the New York State Department of Health (the Department) before use in making Service Authorization Request determinations or requiring prior approval for such services.

i. Submission

- A. Each MMCP that chooses to adopt criteria for the authorization and utilization management of hormone therapy and surgery for the treatment of gender dysphoria must submit the criteria and related policies and procedures (and any subsequent amendment to such information), electronically to the Department's Bureau of Managed Care Certification & Surveillance (BMCCS) BML:
bmccsmail@health.ny.gov
Subject: Attention: Medical Director – gender dysphoria treatment standards for Department review and approval prior to use.
- B. The submission must include the MMCP's Chief Medical Officer's approval of its criteria for the authorization and utilization management of hormone therapy and surgery for the treatment of gender dysphoria.
- C. Any change to a MMCP's criteria or related policies and procedures for the authorization and utilization management of hormone therapy and surgery for the treatment of gender dysphoria must be submitted to the Department for review and approval prior to use.

ii. Authorization Requirements

To be considered satisfactory, MMCP policies and procedures for the review of Service Authorization Requests and plan appeals related to hormone therapy and surgery for the treatment of gender dysphoria must, at a minimum:

- A. Comply with all relevant statutes and regulations, including but not limited to 42 CFR Part 438, New York State Public Health Law Article 49, 18 NYCRR 505.2(l) and the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract;
- B. Comply with all billing and coverage guidance issued by the Department;

- C. Ensure that all service authorization determinations for hormone therapy and surgery for the treatment of gender dysphoria are determined as fast as the enrollee's condition requires;
- D. Not include time limits or requirements for submission of clinical documentation in support of a Service Authorization Request that have the effect of delaying or barring access to medically necessary services;
- E. Provide for at least one attempt to conduct a peer to peer consultation with the ordering provider prior to issuing an adverse determination;
- F. Ensure that at least one clinical peer involved in adverse determinations and plan appeals has clinical expertise in the treatment of gender dysphoria; and
- G. In the case of an adverse determination or upheld denial on appeal, ensure the notice of decision includes:
 - i. If the decision is administrative, the specific benefit coverage criteria that has not been met or other specific reason for denial; or
 - ii. If the decision is regarding medical necessity/utilization review, the clinical rationale specifying:
 - a. How the documentation provided does not support the enrollee's diagnosis of gender dysphoria, or
 - b. How the documentation provided does not support the medical necessity of the proposed treatment for the enrollee's gender dysphoria, or
 - c. There was not enough information to make a decision, and, for initial adverse determinations, what specific information would be necessary for review on appeal.

iii. **Criteria requirements**

To be considered satisfactory, MMCP criteria for the authorization and utilization management of hormone therapy and surgery for the treatment of gender dysphoria must, at a minimum:

- A. Be based on evidenced-based practice and/or well-established clinical practice guidelines, when available;
- B. Be specific to the treatment of gender dysphoria and not transfer review to criteria designed for determining medical necessity of the proposed therapy, service, surgery, or procedure for individuals without the diagnosis of gender dysphoria;
- C. Include a definition of gender dysphoria that is consistent with DSM-5; recognize that gender dysphoria affects people of all genders, and is not limited to people with binary gender identities;

- D. Be free from prejudicial criteria or criteria that limits the scope of Medicaid coverage for treatment of gender dysphoria;
- E. Consider the best interests of the enrollee's health, including the unique clinical profile and unique clinical needs, when determining the appropriateness of hormone therapy and surgery for the treatment of gender dysphoria;
- F. Comply with regulations specified in 18 NYCRR 505.2(*l*), taking into account the following standards pertaining to surgery for the treatment of gender dysphoria:
 - i. Regarding the procedures listed under **paragraph (4)** of 18 NYCRR 505.2(*l*):
 - a. MMCPs may apply administrative prior authorization requirements, however, **MMCPs may not conduct utilization review and must accept the enrollee's treating provider's determination of medical necessity**;
 - b. For procedures that require specific anatomical/body part size, shape, feature, presentation or assessment as part of those procedures' service coverage criteria, MMCPs must accept the enrollee's treating provider's determination of the enrollee's anatomical/body part size, shape, feature, presentations and/or assessment;
 - i. MMCPs shall not include the evaluation of photographic documentation in the administrative prior authorization processes of procedures that require specific anatomical/body part size, shape, feature, presentation or assessment as part of those procedures' service coverage criteria.
 - ii. Hormone therapy is necessary if it is appropriate to the enrollee's gender goals, recommended by the enrollee's treating provider, clinically appropriate for the type of surgery requested, not medically contraindicated, and the enrollee is otherwise able to take hormones. Ref 18 NYCRR 505.2(*l*)(2); (3)(i)(b);
 - iii. The two qualified New York State licensed health professionals, who must independently assess and refer the enrollee for the surgery, service or procedure, do not have to be practicing at different organizations. Ref 18 NYCRR 505.2(*l*)(3)(i);
 - iv. Letters written by the qualified New York State licensed health professionals, who are referring the enrollee for the surgery, service or procedure:
 - a. Must be accepted as an attestation of the member's condition and circumstances without additional supporting documentation or justification; and
 - b. Must not be looked at individually, but rather must be looked at together in their totality. MMCPs must accept the referral letters as being satisfactory, if the totality of the referral letters together indicate that the enrollee:
 - i. Has a persistent and well-documented case of gender dysphoria, and;

- ii. Has received hormone therapy appropriate to the enrollees gender goals, which shall be for a minimum of 12 months in the case of an enrollee seeking genital surgery, unless such therapy is medically contradicted or the enrollee is otherwise unable to take hormones, and;
 - iii. Has lived for 12 months in a gender role congruent with the enrollee's gender identity, and has received mental health counseling as deemed medically necessary by the enrollee's treating NYS licensed health professional, and;
 - iv. Has no other significant medical or mental health conditions that would be a contraindication to the surgery, or if so, that those are reasonably well-controlled prior to the surgery; and
 - v. Has the capacity to make a fully informed decision and to consent to the treatment. Ref 18 NYCRR 505.2(l)(3)(i);
- v. The duration and frequency of mental health counseling is dependent on the enrollee's unique clinical profile and biopsychosocial circumstances. There is no requirement that mental health counseling be provided continuously for 12 months prior to surgery. Ref 18 NYCRR 505.2(l)(3)(i)(c); and
- vi. Regarding the procedures mentioned **under paragraph (5)** of 18 NYCRR 505.2(l), **which are subject to medical necessity review and prior approval**, coverage consideration must be given to provider requested surgeries, services, and procedures (regardless of the perceived nature, type, or category of the requested service, surgery or procedure) in cases where the requesting provider demonstrates that the requested surgeries, services, and procedures are medically necessary for the treatment of the enrollee's gender dysphoria.
 - a. Requested services, surgeries, and procedures for the treatment of gender dysphoria shall not be automatically denied on basis that they are cosmetic in nature, but must be reviewed to determine medical necessity for the treatment of the enrollee's gender dysphoria.