

## **Table of Contents**

1.0	Description of the Procedure .....	1
2.0	Eligible Recipients .....	1
2.1	General Provisions .....	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age .....	1
3.0	When the Procedure Is Covered .....	2
3.1	Specific Criteria .....	2
4.0	When the Procedure Is Not Covered .....	2
4.1	General Criteria.....	2
5.0	Requirements for and Limitations on Coverage .....	3
5.1	Prior Approval .....	3
6.0	Providers Eligible to Bill for the Procedure.....	3
7.0	Additional Requirements .....	3
7.1	Documentation.....	3
8.0	Billing Guidelines .....	3
8.1	Claim Type .....	4
8.2	Diagnosis Codes .....	4
8.3	Procedure Codes .....	4
8.4	Reimbursement Rate.....	4
9.0	Policy Implementation/Revision Information.....	4

## **1.0 Description of the Procedure**

Gender transformation is reconstructive surgery performed to correct an intersex state. An intersex state is a condition in which the appearance of the external genitalia is either ambiguous or at variance with the recipient's chromosomal or gonadal gender.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

**Basic Medicaid Billing Guide:** <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### **3.0 When the Procedure Is Covered**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### **3.1 Specific Criteria**

Gender transformation surgery is covered as reconstructive surgery when the congenital anomaly is discovered before two years of age or at the development of pronounced secondary sex characteristics during puberty.

### **4.0 When the Procedure Is Not Covered**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### **4.1 General Criteria**

Gender transformation is not covered when the criteria listed in **Section 3.0** are not met.

## 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 5.1 Prior Approval

Prior approval is required.

## 6.0 Providers Eligible to Bill for the Procedure

Physicians enrolled in the N.C. Medicaid program who perform this service may bill for this service.

## 7.0 Additional Requirements

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 7.1 Documentation

Medical documentation that substantiates that the anomaly was present prior to the age of two, **OR** that the development of pronounced secondary sex characteristics occurred during puberty, must be submitted with the prior approval request form along with a complete plan of care.

## 8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

**8.1 Claim Type**

Providers bill professional physician services on the CMS-1500 claim form.

**8.2 Diagnosis Codes**

Providers must bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity.

**8.3 Procedure Codes**

CPT codes that describe the planned surgery should be billed.

**8.4 Reimbursement Rate**

Providers must bill their usual and customary charges.

**9.0 Policy Implementation/Revision Information**

**Original Effective Date:** January 1, 1985

**Revision Information:**

<b>Date</b>	<b>Section Updated</b>	<b>Change</b>
1/01/04	Section 7.0	Added requirement for submission of plan of care with prior approval request.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5 and 7	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age