**Connecticut Department of Social Services**
**Medical Assistance Program** **Provider Bulletin 2016-66**
www.ctdssmap.com **October 2016**

**TO: Physicians, Physician Assistants, Advanced Practice Nurse (APRNs), Nurse Midwives and Hospitals**
**RE: Treatment for Gender Identity Disorder – Gender Reassignment Surgery and Procedures**

This bulletin provides guidance to physicians and hospitals related to gender reassignment surgical procedures to treat gender dysphoria under the Connecticut Medical Assistance Program (CMAP) for eligible HUSKY Health members under HUSKY A, C and D. Coverage for gender reassignment surgical procedures and associated procedures that are deemed medically necessary to treat gender dysphoria became effective March 1, 2015 under CMAP.

**Enrollment Requirement**

All providers (physicians and hospitals) must be enrolled and have a valid and active provider agreement on file with CMAP in order to receive reimbursement for gender reassignment surgical procedures performed to treat gender dysphoria for HUSKY Health members. As part of the signed provider agreement, all providers must accept CMAP reimbursement as payment in full for the services covered and approved. For more information on enrollment, or to enroll under the CMAP, please contact the Provider Assistance Center at 1-800-842-8440 or visit the CMAP Web site at www.ctdssmap.com and select "Provider" and then "Provider Enrollment" to access the Connecticut Medical Assistance Program Provider Enrollment/Re-enrollment Wizard.

**HUSKY Health Policy**

The HUSKY Health policy and procedure for gender reassignment surgery is posted on the provider section of the HUSKY Health Web site at www.huskyhealth.com and outlines clinical guidelines and procedures for requesting authorization for gender reassignment surgery and associated procedures related to gender reassignment. This policy lists the minimum required criteria that must be met prior to submitting a prior authorization request for gender reassignment surgery and procedures.

**Prior Authorization**

Physicians must request prior authorization for all medically necessary services related to a gender reassignment surgery. For gender reassignment surgery, the physician is responsible for obtaining the prior authorization prior to rendering services. Physicians must request gender reassignment surgery under either procedure code 55899 (unlisted procedure, male genital system) or 58999 (unlisted procedure, female genital system (nonobstetrical) **and** must list the applicable procedure code(s) for each component to be performed as part of the overall gender reassignment surgery. Each individual service must be listed on the prior authorization request with a fee in addition to procedure code 55899 or procedure code 58999 in order for the authorization to be priced appropriately.

As with any prior authorization request, providers must submit all necessary supporting clinical documentation to substantiate the medical necessity for the services requested. If surgical treatment spans several dates of service, prior authorizations will be granted for each individual surgical date of service.

Prior authorization requests for gender reassignment surgery can be submitted for HUSKY A, C, and D members. As a reminder, gender reassignment surgery and procedures to treat gender dysphoria are not currently covered under HUSKY B.

Prior authorizations should be submitted to the medical administrative service organization, Community Health Network of Connecticut (CHNCT). The forms for an outpatient prior authorization request and an inpatient surgery/procedure are located on the provider section of the HUSKY Health Web site at www.huskyhealth.com. Providers should select

"For Providers", then select "Provider Bulletins & Forms", and then select the appropriate form under the "Provider Forms" panel. Completed prior authorization forms should be submitted to (203) 265-3994. For questions on prior authorization, please contact CHNCT at 1-800-440-5071 and select the prompt for medical authorizations.

**Reimbursement**

Professional Reimbursement

For dates of service November 1, 2016 and forward, prior authorization requests for professional services related to gender reassignment surgery and related procedures will be priced based on the rates listed on the Gender Reassignment Procedure and Surgery Pricing List located in the Fee Schedule Instructions on the CMAP Web site. The prior authorization will be priced using multiple surgical procedure reduction guidelines. When multiple procedures are performed on the same date of service, by the same physician, the primary service (as determined by the Medicare relative value unit for the procedure code) will be reimbursed at 100% and the reimbursement for the secondary and subsequent procedure codes will be reduced by 50% for each. Each individual component that will be performed as part of the overall gender reassignment surgery on a single date of service will be priced in order to determine the total allowed amount for the overall surgery.

Although the prior authorization will be submitted with procedure 55899 or 58999 AND each individual procedure code that will be performed as part of the overall surgical procedure, claims should be submitted with **only** procedure code 55899 or 58999. Claims must also be submitted with the diagnosis code **F64.1 "Gender identity disorder in adolescence and adulthood"**. Providers are reminded to bill their usual and customary charges.

To access the Gender Reassignment Procedure and Surgery Professional Service Pricing List from the www.ctdssmap.com Web site, go to "Provider" and then to "Provider Fee Schedule Download". Click "I Accept" at the end of the Connecticut Provider Fee Schedule End User License Agreements and then click on "Fee Schedule Instructions" in the red text at the top of the page. Scroll down to the Gender Reassignment Procedure and Surgery Pricing List.

Inpatient Hospital Reimbursement

Inpatient hospital reimbursement for medically necessary gender reassignment surgery is priced utilizing CMAP's current All Patient Refined - Diagnostic Related Group (APR-DRG) methodology. All CMAP enrolled hospitals can utilize the DRG calculator to determine the reimbursement for an inpatient stay for gender reassignment surgery. Out-of-state and border hospitals will also receive APR-DRG based reimbursement using the Connecticut statewide average. To access the DRG calculator and for more information on in-state, out-of-state and border hospital reimbursement, go to the CMAP Web site: www.ctdssmap.com and select "Hospital Modernization".

Outpatient Hospital Reimbursement

Effective for dates of service July 1, 2016 and forward, outpatient hospital reimbursement for medically necessary gender reassignment procedures and surgeries is priced utilizing the Outpatient Prospective Payment System – Ambulatory Payment Classification. To determine which procedures are covered and how procedures are reimbursed, outpatient hospitals should review the CMAP addendum B located on the CMAP Web site at www.ctdssmap.com. To access this document, select "Hospital Modernization" and then scroll to "CMAP Addendum B (excel)". For services rendered prior to July 1, 2016, payment was based on Revenue Center Codes (RCC). Some of the RCCs paid based on fixed fees and some of the RCCs were paid based on a ratio of costs to charges. Please refer to the Outpatient Hospital Fee Schedule located on the CMAP Web site at www.ctdssmap.com for RCC information for dates of service prior to July 1, 2016.