Oregon Health Plan Coverage of Gender Dysphoria

LGBTQ Community Partners Frequently Asked Questions (FAQ)

Background

Basic Rights Oregon has been advocating for the updating and modernization of gender transition (and related) services within the Oregon Health Plan (OHP) for several years. We are extremely pleased to see these changes come to fruition. We have received a high number of inquiries from community partners, and this FAQ is designed to informally address them. For the official policy and procedures, please contact the Oregon Health Authority (OHA).

While this new health care policy makes it possible for transgender people to get medically necessary transgender health care treatments within the Oregon Health Plan, with all policy changes of it takes time to ensure that full implementation works to meet the health needs of all transgender communities in Oregon. Basic Rights Oregon is working with the Oregon Health Authority and community organizations like Oregon Health & Science University, Legacy Health TransActive Gender Center and Q Center to ensure that implementation goes as smoothly as possible. When more information becomes available, we will update this FAQ and our websites with links from the Oregon Health Authority. http://www.oregon.gov/oha/herc/FactSheet/Gender%20dysphoria%208-28.pdf

This document was produced by Basic Rights Oregon as a resource for providers; it should not be construed as legal advice. Medicaid providers should seek official information on implementation http://www.oregon.gov/oha/healthplan/pages/providers.aspx

What is covered under the new guidelines for the Oregon Health Plan?

Effective January 1, 2015, the State of Oregon has extended coverage for most transition-related healthcare under the State's Medicaid Program, the Oregon Health Plan. These services include coverage for puberty suppression, primary care and specialist doctor visits, mental health care visits, cross-sex hormones, anti-androgens, lab work and some surgeries.

What was the final language approved for coverage?

The following appears in the "prioritized list of covered services" for Oregon Health Plan:

> **Guideline for Gender Dysphoria (Line 413):** Hormone treatment is included on this line for use in delaying the onset of puberty and/or continued pubertal development with GnRH analogues for gender questioning children and adolescents. This therapy should be

initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, but 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 strongly encouraged for continued puberty suppression therapy. Cross-sex hormone therapy is included on this line for treatment of adolescents and adults with gender dysphoria who meet appropriate eligibility and readiness criteria.

What are the requirements to access care?

To qualify for cross-sex hormone therapy, the patient must:

1. Have persistent, well-documented gender dysphoria
2. Have the capacity to make a fully informed decision and to give consent for treatment under Oregon law
3. Have any significant medical or mental health concerns reasonably well controlled
4. have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org).

What are the requirements to qualify for sex reassignment surgery?

Sex reassignment surgery is included for patients who meet eligibility criteria. To qualify for surgery, the patient must:

1. Have persistent, well documented gender dysphoria
2. Have completed 12 months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not medically necessary or hormones cause negative reactions due to illnesses that are sensitive to those hormones. Starting October 1st, hormone therapy guidelines pertain to only genital surgeries.
3. Have completed 12 months of living in a gender role that aligns with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
4. Have the capacity to make a fully informed decision and to give consent for treatment under Oregon law
5. Have any significant medical or mental health concerns reasonably well controlled
6. For breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.
7. For genital surgeries, have two referrals from mental health professionals provided in accordance with the version 7 WPATH Standards of Care.

How are these guidelines different from the World Professional Association for Transgender Health (WPATH) guidelines?

The Oregon Health Evidence Review Commission (HERC) relied heavily upon the WPATH

standards of care to create its guidelines. Basic Rights Oregon and partners advocated for the guidelines to differ from the WPATH standards of care in the following ways:

1. Age of Medical Consent: In Oregon, the minimum age of medical consent is 15 years. Basic Rights Oregon and TransActive Gender Center advocated that these guidelines follow Oregon State Law with regard to age of medical consent. Patients should be able to demonstrate the capacity to make a fully informed decision and to give consent to treatment, regardless of age. However, nothing in Oregon law requires a health care provider to provide medical services to a minor or to safeguard the confidentiality of a minor. In most cases, providers will encourage (and in some cases require) family engagement and support unless it would endanger the patient.

2. Qualified Mental Health Providers: Licensed Master's level clinicians should be sufficient to meet this requirement for Oregon Health Plan. It is important to note: each individual surgeon will determine what their requirements are to qualify for surgery and this may mean a PhD or MD level letter. Please encourage clients to inquire early with about their chosen surgeon's requirements for surgery.

3. "Real Life Experience": The WPATH SOC suggests a 12-month "real life experience" for patients seeking genital surgeries, which is repeated in the OHP guidance, except for all surgeries. However, Basic Rights Oregon successfully advocated for a qualifying clause. "Unless a medical and a mental health professional both determine that this requirement is not safe for the patient." In some instances, coming out as transgender before accessing transition-related care, may not be safe for patients. A mental health provider and primary care provider should note in their referral letters for prior approval if this condition is being waived and for what reasons. This provision specifically speaks to safety, and not other reasons. For clients who do not have a binary identity, we believe 12 months with a consistently expressed or asserted identity should be sufficient to meet this requirement for surgery. However, each individual CCO will make a determination on this matter. If difficulty is encountered in securing coverage for non-binary identified patients, please contact Basic Rights Oregon.

Who can provide these services?

Any qualified licensed mental health professional, primary care doctor, specialist, or surgeon who accepts Oregon Health Plan, or who contracts with one of OHP's coordinated care organizations, can provide these services. Providers should have familiarity with treating patients with Gender Dysphoria and be familiar with the World Professional Association for Transgender Health - Standards of Care, or the Endocrine Society guidelines: "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline."

Mental Health Care

Is prior approval needed for mental health care?
No, there should be no requirement for prior approval to provide mental health care by a qualified mental health professional.

At what age can people receive covered mental health care?
Coverage should be available for all ages.

What is the age of consent for mental health?
In Oregon, age of medical consent for mental health care is 14 years old. Meaning, people who are 14 can consent themselves to treatment for gender dysphoria without requiring parental consent. This is one year younger than the age of medical consent which is 15.

What is a "thorough psychosocial assessment"?
Each clinician will need to determine what they consider to be a thorough psychosocial assessment. The WPATH standards of care outline very thoroughly what should be included in letters referring patients for hormones or surgery and this is generally a good guide. It is important to note the Oregon Health Plan requires specific written documentation (letters), including the phrases "persistent, well-documented gender dysphoria," and "have the capacity to make a fully informed decision and under Oregon law are able to give consent for treatment," and "have any significant medical or mental health concerns reasonably well controlled."

What is meant by "persistent, well-documented gender dysphoria?"
This is something that each clinician will need to make a decision about. We would refer clinicians to the WPATH standards of care for more guidance.

Hormones

Is prior approval needed for hormone treatment?
We do not believe that CCOs will require letters of psychosocial assessment prior obtaining a prescription for puberty blockers, hormones or anti-androgens. However, your CCO may require pre-authorization from your medical provider for the prescription before you receive hormone treatments.

What are the requirements set out by Oregon Health Plan?
Cross-sex hormone therapy is included on this line for treatment of adolescents and adults with gender dysphoria who meet appropriate eligibility and readiness criteria. To qualify for cross-sex hormone therapy, the patient must:

1. Have persistent, well-documented gender dysphoria
2. Have the capacity to make a fully informed decision and to give consent for treatment under Oregon law
3. Have any significant medical or mental health concerns reasonably well controlled

4. have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org).

If referral letters are required by primary care providers to receive hormone, puberty suppression, or anti-androgen treatment, what needs to be in the letter?

If a referral letter is requested by a CCO, providers should secure a letter from a referring qualified mental health provider attesting to the four requirements listed above.

Surgery

What should be included in a referral letter for surgery?

Physicians and therapists should work with patients to obtain prior approval from their Coordinated Care Organization for covered surgeries. The CCO will require letters from two qualified mental health professionals for genital surgeries and one letter for chest and breast surgeries. These assessments should document the following:

1. Have persistent, well documented gender dysphoria
2. Have completed 12 months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not medically necessary or hormones cause negative reactions due to illnesses that are sensitive to those hormones. Starting October 1st, 2016, these guidelines only pertain to genital surgeries.
3. Have completed 12 months of living in a gender role that aligns with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
4. Have the capacity to make a fully informed decision and to give consent for treatment under Oregon law
5. Have any significant medical or mental health concerns reasonably well controlled
6. For breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.
7. For genital surgeries, have two referrals from mental health professionals provided in accordance with the version 7 WPATH Standards of Care.
8. The Primary Care Provider is probably the best person to collect and submit this information to the CCO for the patient, along with their own letter detailing any of the above information as appropriate.

Where can patients get surgery?

CCOs will be required to arrange appropriate coverage for surgical services for covered patients who meet OHP guidelines. CCOs do have some discretion in this regard--patients may be directed to surgeons who are within the CCOs network. Surgeons in Oregon are performing many covered surgeries. We would encourage providers to connect with Oregon Health & Science University, Legacy Health, or other local surgeons competent in providing transition related surgeries.

Patients who have an "open card" will need to work directly with OHA's Health Systems Division to find a covered surgeon.

What about surgeries not available in Oregon?

Not all covered surgeries are available in Oregon, but nearly all will be available by January 2016. Patients, primary care providers, and therapists should be in direct contact with CCOs to coordinate surgeries that may need to be performed out of state. Each CCO will need to initiate a process to identify an appropriate surgeon and contract directly with that surgeon to provide covered surgeries. If the patient is on open card, the patient will work directly with the Health Systems Division to identify an appropriate surgeon.

Can patients choose their own surgeon?

This is unclear. Patients will need to work directly with their CCO to identify an appropriate, competent surgeon. If the CCO has already contracted with a surgeon, or has a surgeon "in network" it is likely that just like for all other OHP medical services, the patient will be directed to that surgeon. Patients can request from their CCO evidence such as fellowships, residencies, licensure or proof of past experience or training in performing transition related surgeries that a surgeon is competent to provide the surgery required. If, upon consultation, a patient is uncomfortable with the skill or ability of a surgeon selected by a CCO, the patient should consult the CCO and request a different surgeon. Patients also have the right to a second opinion before a surgery.

What are the approved CPT Codes that are covered and Services?

The following is a partial list of CPT billing codes. A complete list is in the appendix:

CPT code	Code description
14000-14001	Adjacent Tissue Transfer
15200-15201	Full Thickness Skin Graft
17110,17111	Laser Hair Removal, starting October 1, 2016
17380	Electrolysis epilation, each 30 minutes
19303-19304, 19318,	Mastectomy; reduction mammaplasty with reconstruction
19350	Nipple/areola reconstruction
19316, 19324-19325, 19340, 19342, 19350, 19357-19380	Mammaplasty augmentation; mastopexy
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra

53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
54120	Amputation of penis; partial
54125	removal of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55150	Resection of scrotum
55175-55180	Scrotoplasty
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical
57106-57107	Vaginectomy, partial removal of vaginal wall;
57110-57111	Vaginectomy, complete removal of vaginal wall
57291-57292	Construction of artificial vagina
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
58150, 58152, 58180, 58260, 58262, 58275-58291, 58541-58544, 58550-58554, 58570-58573	Hysterectomy
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	Laparoscopy, surgical; with removal of adnexal structures

58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
58940	Oophorectomy, partial or total, unilateral or bilateral;
90785, 90832-90840, 90846-90853, 90882, 90887, 96101	Psychotherapy/Mental health care
97001, 97110, 97140, 97530	Pelvic Physical Therapy, pre/post-operative for surgical purposes only, starting October 1, 2016

What about surgeries that don't use those specific CPT codes?

OHA and CCOs have confirmed that transgender specific CPT codes will not be required in order for patients to access gender affirming surgeries. Existing CPT codes will be sufficient for billing purposes, as long as a diagnosis code related to gender identity disorder is included when billing for services. Please include ICD-9 codes related to gender identity: 302.85 (Gender identity disorder in adolescents or adults) and after OHA has implemented ICD-10 codes: ICD10:F64.1-F64.9 (Gender identity disorder).

What transition related care is specifically excluded or not covered?

According to the HERC guidance, rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal in cases other than surgical sites, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic. After covered surgeries are performed, revisions sought for cosmetic reasons are also not covered, however revisions for complications including those impeding function or causing pain are covered.

Who do providers and patients contact with questions?

Questions about specific coverage, referrals to covered surgeons, or for prior approval should be directed to a patient's Coordinated Care Organization.

Where can I find out more information about denials, appeals, and rights of my patient under Oregon Health Plan?

Oregon Law Help has a great FAQ on rights and resources under Oregon Health Plan, including how to deal with a denial of coverage. Patients only have 45 days to appeal a denial or request a hearing! oregonlawhelp.org/resource/oregon-health-plan-if-you-are-denied-services

What can my patients do if they are unhappy with the service they receive for any reason?

CCO members who are not satisfied with the services they receive under the Oregon Health Plan have the right to file a complaint if they have a general concern about their care or services. Every

CCO is required to have written procedures for taking complaints. The CCO member handbook will describe the complaint process. Patients are encouraged to submit complaints in writing, provide a copy to the doctor and keep a copy for your records.

The CCO should make a decision about the complaint within five work days, but they may take up to 30 days to resolve the complaint if they need more time. If the patient told the CCO about your complaint and did not write it, they can make their decision by telling the patient instead of writing it. If the patient wrote the complaint, the CCO has to write the decision. .

Who do I contact if I need more help for my patient?
If your advocacy with a CCO has been unsuccessful you can contact: The Client Services Unit of OHA at 800-273-0557. The Oregon Health Plan also has an Ombudsperson who can help you with discrimination complaints, 877-642-0450 or 503-947-2346. You can also contact the Governor's Advocacy Office at 800-442-5238.

Appendix

The following is an excerpt of the approved codes and services for the treatment of Gender Dysphoria.

- Line: 317 Condition: GENDER DYSPHORIA (See Guideline Note 127)
    - Treatment: MEDICAL AND SURGICAL TREATMENT/PSYCHOTHERAPY
- ICD-10: F64.1-F64.9,Z87.890
- CPT: 14000,14001,15200,15201,17380,19303,19304,19316-19325,19340-19350,53415-53430,54120,54125,54520, 54690,55150-55180,55866,55970,55980,56620,56625,56800-56810,57106,57107,57110,57111,57291-57296, 57335,57426,58150-58180,58260,58262,58275-58291,58541-58544,58550-58554,58570-58573,58660,58661, 58720,58940,90785,90832-90840,90846-90853,90882,90887,96101,98966-98969,99051,99060,99070,99078, 99201-99215,99281-99285,99341-99355,99358-99378,99381-99404,99408-99416,99429-99449,99487-99498, 99605-99607
- HCPCS: G0176,G0177,G0396,G0397,G0459,G0463,G0466,G0467,G0469,G0470,H0004,H0023,H0032,H0034,H0035, H2010,H2011,H2014,H2027,H2032,H2033,S9484,T1016
- Starting October 2016, CPT 17110, 17111, 97001, 97110, 97140, 97530