Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Cleveland Field Office
Cleveland, Ohio

Appeal of:	**C. Lauderdale**	ALJ Appeal No.:	**1-2978123060**
Enrollee:	**C. Lauderdale**	Medicare Part:	**C**
HICN:	*******3224A**	Before:	**Lewis T. Booker, Jr.** U.S. Administrative Law Judge

DECISION

After careful consideration of all the evidence in the record, a **FAVORABLE** decision is entered for the Appellant/Enrollee, C. Lauderdale.

Procedural History

Ms. Lauderdale is enrolled in AARP Medicare Complete (HMO) Plan (the Plan), which is insured through United Healthcare. On November 25, 2014, the Plan denied the Enrollee's prior authorization request to cover a vaginoplasty. (Exh. 3, p. 38). Thereafter, the Enrollee appealed the Plan's initial denial, and the Plan issued an unfavorable redetermination decision against the Enrollee. (Exh. 3, p. 34).

The Enrollee's case was forwarded to the Maximus Federal Services, an Independent Review Entity (IRE), for review. On December 24, 2014, Maximus agreed with the Plan and ruled that the procedure was contraindicated due to the Enrollee's psychiatric instability. (Exh. 3, pp. 1-7).

The Appellant filed a timely appeal and request for an Administrative Law Judge (ALJ) Hearing, pursuant to 42 C.F.R. § 422.602(a) (Exh. 4, p. 1). The ALJ provided due notice to the Appellant, the Plan, and the IRE, and held a hearing by telephone conference on March 31, 2015. Ms. Lauderdale and her attorney, Ezra Young, appeared at the hearing. Vivian Hermiz, Senior Consultant, appeared on behalf of the Plan. I entered Exhibits 1-8 into the record without objection and further accepted and entered Exhibit 9, United Healthcare Coverage Determination Guideline for Gender Identity Disorder/Gender Dysphoria Treatment, without objection. As to that final exhibit I do note, as raised at the hearing, that it does not apply to the specific Plan at issue and that it might not be the most current version of the Guideline.

Issue

The issue on appeal is whether the Plan, under the applicable Medicare laws, regulations, guidance, and policies, or under the terms of the Enrollee's contract with the Plan, must cover the requested gender reassignment surgery, specifically vaginoplasty, to treat the Enrollee's gender identity disorder.

Findings of Fact

These facts are established by the record, including the testimony:

Ms. Lauderdale is enrolled in AARP Medicare Complete (HMO) Plan for calendar year 2014 and 2015. Although she recently moved to a different county, and thus has had to enter into a new contract (because of "local area" definitions) with the Plan, her primary residence is still in the state of Texas. In her testimony, she acknowledged that the surgery that she requests is an "excluded" benefit.

Ms. Lauderdale is 54 years old, and she was born with both male and female genitals. (Exh. 3, p. 9). She was diagnosed with Gender Identity Disorder/Gender Dysphoria by Dr. Sheila Loboprabu, Staff Psychiatrist within the General Mental Health Clinic at the VA Medical Center in Houston, Texas. (Exh. 2, p. 33). At the age of 46 (2006), Ms. Lauderdale began living full-time as a woman. Since her decision, she has had her testicles and scrotum removed, she has received hormone therapy, and she has undergone a breast augmentation procedure. (Exh. 3, p. 9). Additionally, she receives psychiatric care from Dr. Loboprabu and other professionals to deal with the transition process from male to female. (Exh. 2, p. 32).

In November of 2014, Dr. Loboprabu consulted with Dr. Marci Bowers, who has performed over 1200 male to female genital reassignment surgeries, about possible sex reassignment surgery for Ms. Lauderdale. (Exh. 2, pp. 31-33; Exh. 3, pp. 21-22). Following the consultation, Dr. Bowers agreed with Dr. Loboprabu that Ms. Lauderdale is a good candidate for sex reassignment surgery. (Exh. 3, p. 21). Both Dr. Bowers and Dr. Loboprabu agreed that Ms. Lauderdale meets or exceeds the readiness and eligibility criteria for sex reassignment surgery set by the World Professional Association for Transgender Health (WPATH), a self-described "interdisciplinary professional and educational organization devoted to transgender health." Additionally, both physicians agreed that the gender reassignment surgery is medically necessary for Ms. Lauderdale.

During the course of the hearing, Ms. Hermiz stated that the Evidence of Coverage language for Medicare plans is always subject to approval by the Centers for Medicare and Medicaid Services. The Plan submitted its 2014 and 2015 EOC language, specifically that excluding sex change operations, to CMS for approval. Ms. Hermiz also noted that the Plan had not received any guidance from CMS about possible changes in the coverage policies.

Legal Framework

I. ALJ Review Authority

The ALJ within the Office of Medicare Hearings and Appeals performs a de novo review of those cases where an individual or organization is dissatisfied with the reconsideration of an initial determination, provided that there is a sufficient amount in controversy, and also that the appellant files the appeal in a timely fashion. 42 U.S.C. § 1395ff(b)(1)(A); *see also* 42 C.F.R. §§ 422.1000 and 422.1002. *See generally* 70 Fed. Reg. 36386, 36387 (June 23, 2005) (delegation of Secretary's power specifically to OMHA to conduct reviews). The ALJ will consider all issues brought out in the initial, reconsidered, or revised determination, that were not decided entirely in the appellant's favor. Hearing procedures generally are covered in Part 405 of title 42 of the Code of Federal Regulations.

II. Principles of Law

A. The Social Security Act and Regulations

Section 1862(a)(1) of the Social Security Act, 42 U.S.C. § 1395y(a)(1), excludes Medicare payment for services which "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Medical necessity cannot be established if the safety and effectiveness of a procedure, drug, or device is unknown.

While enrolled in an MA plan, an enrollee is entitled to and restricted by the limitations and conditions of that program with respect to Medicare coverage and reimbursement. In turn, the MA plan must make available to an enrollee, or provide reimbursement for, at least all services covered under Part A and Part B of Medicare. *See* 42 C.F.R. § 422.101.

Section 1852 of the Social Security Act, 42 U.S.C. § 1395w–22, states that under Medicare Part C, a Medicare Advantage Organization offering an MA plan must provide enrollees with coverage of those items and services for which benefits are available under parts A and B. The Regulations support this basic requirement in 42 C.F.R. Section 422.100(c), where it states: "An M+C plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits." 42 C.F. R. Section 422.100(c)(1) defines basic benefits as ". . . all Medicare-covered services, except hospice services, and additional benefits as defined in § 422.2 and meeting all requirements in § 422.312."

The Secretary may issue binding National Coverage Determinations on particular matters. An ALJ must follow the requirements of an applicable NCD. 42 C.F.R § 405.1063.

B. Evidence of Coverage

The Plan's Evidence of Coverage (EOC) Chapter 4, Section 3.1, provides that sex change operations are excluded from coverage as the procedures are not covered under Original Medicare. *See* Plan's EOC at pages 4-36 to 4-37.

On September 1, 2014, United Healthcare, which administers AARP Medicare Complete (HMO), issued guideline number CDG.011.03 to provide coverage determination guidelines for gender identity disorder/gender dysphoria treatment. The guideline states that most plans administered by United Healthcare exclude coverage for sex transformation surgery; however, plans that cover treatment of gender identity disorder must include coverage of the following medical services: psychotherapy for gender identity disorders, continuous hormone replacement, genital surgery (vaginoplasty), secondary sex characteristics surgery, laboratory testing, and related services. United Healthcare also listed the criteria for coverage of genital surgery. The criteria are: (1) the surgical procedure must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder; (2) the treatment plan must conform with WPATH standards; (3) the covered person must be 18 years-old or older for irreversible surgical interventions; (4) the covered person must complete 12 months of successful continuous full-time real life experience in the desired gender; (5) the covered person must be required to complete continuous hormone therapy; (6) the covered person must meet the definition of gender identity disorder; and (7) the covered person's physician who is performing the procedure must follow the notification process before performing the procedures.

Analysis

As noted above, the Plan states that sex change procedures are excluded under Medicare; however, the Plan's position about Medicare coverage was based in substantial part on a National Coverage Determination, 140.3, found in May 2014 to be invalid. Because of a change in the law, then, "original Medicare" might actually cover the requested operation.

In a lengthy decision, the Departmental Appeals Board ruled that NCD 140.3 might have been based on appropriate medical knowledge and techniques when it was issued in 1981. Because of changes in the understanding of the medical condition of gender dysphoria, however, and because of advances in surgical techniques used to treat that particular illness, the Board invalidated the NCD. *See generally In Re NCD 140.3, Transsexual Surgery*, Docket No. A-13-87, May 30, 2014. CMS on June 27, 2014, via Change Request 8825, officially removed NCD 140.3, "Transsexual Surgery," from its CMS Manual System, and indeed one sees in the decision that CMS made no effort to defend the NCD before the Appeals Board. Thus, neither Medicare nor MA plans, as of May 30, 2014, are able to rely on NCD 140.3 to categorically deny sex reassignment surgery claims.

It is no defense for the Plan, moreover, that CMS approved its EOC language or that CMS has thus far failed to craft guidance for approving gender-reassignment surgery. United Healthcare was obviously aware, based on its issuing the Gender Identity guidance for some of its Plans, of the advances in medical knowledge and technique over the last several decades. Having established the Plan's categorical exclusion of sex change operations as invalid, I must determine whether the Enrollee's request for coverage of vaginoplasty is reasonable and necessary under section 1862 of the Social Security Act, 42 U.S.C. § 1395y, and the Plan's coverage criteria. If it is, then it is a covered benefit under the Plan.

The record is clear that Ms. Lauderdale is diagnosed with gender identity disorder, and she has identified and presented herself as a woman since 2006. More important, as both Ms. Lauderdale's treating psychiatrist and a surgeon (cited extensively in the *NCD 140.3* opinion) attest in their written evidence, vaginoplasty is one of several procedures indicated for the effective treatment for those diagnosed with gender identity disorder. Specifically, the requested vaginoplasty at issue in this case is reasonable and necessary for the treatment of the Enrollee's medical condition, gender identity disorder.

Acknowledging that the guidance in Exhibit 9 does not apply to this specific Plan, I do find it informative and note that with regard to United Healthcare coverage criteria for gender reassignment surgery, the Appellant would have satisfied the coverage criteria set forth by United Healthcare were she in a different Plan. The Enrollee has presented herself full-time as woman since 2006. She has undergone all of the necessary pre-vaginoplasty steps in preparation of this vaginoplasty procedure, including continuous cross-sex hormone therapy. Furthermore, Dr. Bowers, who is scheduled to perform the procedure and has performed over 1200 gender reassignment surgeries, believes she is beyond the point of returning to the original gender. More important, both Dr. Bowers and Dr. Loboprabu agreed that the Enrollee satisfies the gender reassignment surgery standards set by WPATH, standards that have been cited in the DAB decision and standards that take into account the wide range of options available to persons with cases of gender dysphoria. *See* WPATH, Standards of Care, Version 7, available on-line at http://admin.associationsonline.com/uploaded_files/140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf.

Based upon the testimony presented and the documentary evidence reviewed in the record, I find that the requested vaginoplasty procedure is reasonable and necessary under section 1862(a)(1) of the Social Security Act, 42 U.S.C. § 1395y(a)(1). Ms. Lauderdale is a qualified candidate per WPATH guidelines for the procedure.

Conclusions of Law

The Plan is required to cover the vaginoplasty procedure requested by Ms. Lauderdale because the requested procedure, under the specific facts of this case, is reasonable and necessary under section 1862(a)(1) of the Social Security Act, 42 U.S.C. § 1395y(a)(1).

Order

The Plan is **DIRECTED** to process the claim in accordance with this decision.

SO ORDERED.

Dated: APR 24 2015

Lewis T. Booker, Jr.
U.S. Administrative Law Judge

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EXHIBIT LIST

EXHIBIT NUMBER	DESCRIPTION	DATE	NUMBER OF PAGE(S)
1.	**Evidence of Coverage (2014)** AARP Medicare (HMO)		Pre-numbered
2.	**Medical Documents**		1-51.
3.	**Procedural Documents** Reconsideration Decision Case Narrative Notice of Denial of Medical Coverage	 12/24/2014 11/25/2014	1-42
4.	**Request for ALJ Hearing**	02/13/2015	1-33
5.	**Hearing Related Materials** Signed Response (s) to Notice of Hearing		1-12
6.	**Additional Evidence** Department of Veterans Affairs, dated	03/19/2015	1-2
7.	**Overview Papers** From Attorney Ezra Young dated 3/17 to 3/23/2015		1-10
8.	**CD, From Attorney Ezra Young** Response to Position Statement		
9.	**United HealthCare** Coverage Determination Guideline		1-9