CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-03 Medicare National Coverage Determinations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 194	**Date: March 3, 2017**
	Change Request 9981

SUBJECT: Gender Dysphoria and Gender Reassignment Surgery

I. SUMMARY OF CHANGES: The purpose of this CR is to inform contractors that coverage determinations for gender reassignment surgery will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

EFFECTIVE DATE: August 30, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2017
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/ 140/Table of Contents
N	1/140.9/Gender Reassignment Surgery for Gender Dysphoria

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-03	Transmittal: 194	Date: March 3, 2017	Change Request: 9981

SUBJECT: Gender Dysphoria and Gender Reassignment Surgery

EFFECTIVE DATE: August 30, 2016
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I. GENERAL INFORMATION

A. Background: On August 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum (DM) on gender reassignment surgery for gender dysphoria. Importantly, the DM did not create or change existing policy – CMS did not issue a national coverage determination (NCD).

The purpose of this CR is to include an explanatory paragraph about gender reassignment surgery in the Medicare NCD Manual at chapter 1, part 2, section 140.9. This is in response to public inquires to have information about gender reassignment surgery among Medicare coverage information.

B. Policy: Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9981.1	Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9981.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage) , Linda Gousis, 410-786-8616 or Linda.Gousis@cms.hhs.gov (Coverage) , Patricia Brocato-Simons, 410-786-0261 or Patricia.BrocatoSimons@cms.hhs.gov (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare National Coverage Determinations Manual
Chapter 1, Part 2 (Sections 90 – 160.26)
Coverage Determinations

Table of Contents
(Rev.194, Issued: 03-03-17)

140.9- Gender Reassignment Surgery for Gender Dysphoria

(Rev. 194, Issued: 03-03-17, Effective: 08-30-16, Implementation; 04-04-17)

A. General

Gender reassignment surgery is a general term to describe a surgery or surgeries that affirm a person's gender identity.

B. Nationally Covered Indications

N/A

C. Nationally Non-Covered Indications

N/A

D. Other

The Centers for Medicare & Medicaid Coverage (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery. Effective August 30, 2016, after examining the medical evidence, CMS determined that no national coverage determination (NCD) is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria. In the absence of an NCD, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act (the Act) and any other relevant statutory requirements, will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

(This policy last reviewed August 2016.)