CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 189	**Date: June 27, 2014**
	Change Request 8825

SUBJECT: Invalidation of National Coverage Determination 140.3 - Transsexual Surgery

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to implement the Departmental Appeals Board decision consistent with 42 CFR §426.560(b)(2) by removing section 140.3, Transsexual Surgery, from Pub. 100-03, Medicare National Coverage Determinations Manual. Additionally, references to transsexual surgery have been removed from Pub. 100-02, Medicare Benefit Policy Manual.

EFFECTIVE DATE: May 30, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 29, 2014 - (For clarification, 6/29/14 was referred to as the 'effective' date in recent communication; 6/29/14 is the 'implementation' date)

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	16/120/Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
R	16/180/Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

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 obliged 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. 100-02	Transmittal: 189	Date: June 27, 2014	Change Request: 8825

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EFFECTIVE DATE: May 30, 2014
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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to inform you that the Department of Health and Human Services Departmental Appeals Board (DAB) has invalidated National Coverage Determination (NCD) 140.3 "Transsexual Surgery" pursuant to section 1869(f)(1)(A)(iii) of the Social Security Act (SSA). (Docket #A-13-47, Decision #2576) dated May 30, 2014. As a consequence of this decision, NCD 140.3 is no longer valid. Implementation of this decision shall be June 29, 2014.

B. Policy: Because the NCD is no longer valid as of the effective date, its provisions are no longer a basis for denying claims for Medicare coverage of "transsexual surgery" under 42 CFR §405.1060. Moreover, any local coverage determinations used to adjudicate such claims may not be based on or rely on the provisions or reasoning from section 140.3 of Pub. 100-03, Medicare NCD Manual. In the absence of an NCD, contractors and adjudicators should consider whether any Medicare claims for these services are reasonable and necessary under §1862(a)(1)(A) of the SSA consistent with the existing guidance for making such decisions when there is no NCD.

Therefore, the Centers for Medicare & Medicaid Services will implement the DAB decision with this CR consistent with 42 CFR §426.560(b)(2). Section 140.3 will be removed from the Medicare NCD Manual.

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	
8825 - 02.1	Effective for claims with dates of service on and after May 30, 2014, Medicare coverage under section 1862(a)(1)(A) of the SSA for transsexual surgery will be determined by the local Medicare Administrative Contractors.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8825 - 02.2	CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it 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): Pat Brocato-Simons, 410-786-0261 or patricia.brocatosimons@cms.hhs.gov (Coverage), Janet Brock, 410-786-2700 or janet.brock@cms.hhs.gov (Coverage), Lori Ashby, 410-786-6322 or lori.ashby@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 Benefit Policy Manual
Chapter 1 – Inpatient Hospital Services Covered under Part A

120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
(Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" *non-covered* services (e.g., cosmetic surgery, *non-covered* organ transplants, *non-covered* artificial organ implants, etc.), including services related to follow-up care and complications of *non-covered* services which require treatment during a hospital stay in which the *non-covered* service was performed, are not covered services under Medicare. Services "not related to" *non-covered* services are covered under Medicare.

Following are examples of services "related to" and "not related to" *non-covered* services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a *non-covered* service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.

- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a *non-covered* transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a *non-covered* transplant or implant, the services related to the admitting condition would be covered.

- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the *non-covered* transplant, the services would be "related to" *non-covered* services and would also be *non-covered*.

Following is an example of services received subsequent to a *non-covered* inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received *non-covered* services, medical and hospital services required to treat a condition or complication that arises as a result of the prior *non-covered* services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous *non-covered* procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a *non-covered* bladder stimulator, or treatment of any infection at the surgical site of a *non-covered* transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

Medicare Benefit Policy Manual
Chapter 16 – General Exclusions from Coverage

180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
(Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" *non-covered* services (e.g., cosmetic surgery, *non-covered* organ transplants, *non-covered* artificial organ implants, etc.), including services related to follow-up care and complications of *non-covered* services which require treatment during a hospital stay in which the *non-covered* service was performed, are not covered services under Medicare. Services "not related to" *non-covered* services are covered under Medicare.

Following are examples of services "related to" and "not related to" *non-covered* services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a *non-covered* service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.

- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a *non-covered* transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a *non-covered* transplant or implant, the services related to the admitting condition would be covered.

- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the *non-covered* transplant, the services would be "related to" *non-covered* services and would also be *non-covered*.

Following is an example of services received subsequent to a *non-covered* inpatient stay:

After a beneficiary has been discharged from the hospital stay in which the beneficiary received *non-covered* services, medical and hospital services required to treat a condition or complication that arises as a result of the prior *non-covered* services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous *non-covered* procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a *non-covered* bladder stimulator, or treatment of any infection at the surgical site of a *non-covered* transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.