

# Health Care for Transgender New Yorkers: Will Medicaid Pay for Gender-Affirming Procedures?

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This guide can help you navigate the complicated world of Medicaid and Medicaid-related benefits. If Medicaid is your only insurance, this guide will help you gather the evidence you and your surgeon will need to get a PRIOR APPROVAL for your surgery or procedures from Medicaid or your Medicaid insurance company. If you have Medicare or private insurance in addition to Medicaid, you will need to seek coverage from that other insurance first.

It is important for you to be aware that transition-related surgery will be covered by New York's Medicaid program **ONLY** if your health care provider has given you a diagnosis of "gender dysphoria."

**What is "gender dysphoria?"** Gender dysphoria is a diagnosis from a medical professional when the gender assigned at birth does not match the gender with which you identify, and you experience significant distress as a result.

On December 7, 2016, New York State made changes to the types of transition-related surgery covered by Medicaid. These procedures include genital surgery, top surgery, body sculpting, and facial feminization surgery. There is NO list of procedures that Medicaid will and won't pay for. If the procedure is medically necessary for you, it should be covered!

Because the changes happened recently, it is important for you to know that today:

- 👉 A procedure that your Medicaid insurance denied in the past could now be covered *if* it treats gender dysphoria.
- 👉 A procedure that your surgeon tells you will never be covered because Medicaid considers it to be "cosmetic" could now be covered *if* it treats gender dysphoria. For many years, Medicaid had a list of procedures that were considered "cosmetic" no matter why you needed them. That list no longer exists.
- 👉 Insurance companies and health care providers might not know about the changes. If your request for a procedure is denied, you can appeal and show that the care is necessary and should be covered under the new Medicaid rules. **As of May 1, 2018, the appeals process has changed. Please see Step #2A for additional information about appeals.**

## Step 1: Get Two Letters of Medical Necessity

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Medicaid will pay for transition-related surgery if you have TWO health care providers who both agree that the procedure is necessary for you. Your health care providers will each need to write a LETTER referring you to a surgeon for the procedure. These letters must be as follows:

- The first letter must be from a mental health provider who has treated you for a while. The provider must be a NYS-licensed: psychiatrist, psychologist, psychiatric nurse practitioner, or clinical social worker.
- The second letter can be from a provider who just met you once to evaluate you for the procedure. The provider must be a NYS-licensed: physician, psychiatrist, psychologist, psychiatric nurse practitioner, or clinical social worker.

Medicaid requires that the combined two letters describe that YOU:

- 👉 Have a persistent and well-documented case of gender dysphoria *and* the procedure is medically necessary to treat your gender dysphoria *and*
- 👉 Have lived for at least a year in the gender role that matches your gender identity *and*
- 👉 Have received mental health counseling as deemed necessary *and*
- 👉 Have no medical or mental health conditions that would make the procedure medically inappropriate, or if so, that those are reasonably well-controlled prior to procedure *and*

- ☞ Have the capacity to make a fully-informed decision and to consent to the treatment *and*
- ☞ Have received hormone therapy (or describe why hormone therapy is not medically appropriate for you)
  - For genital surgery, the letters must say you have received hormone therapy for at least 1 year (or describe why hormone therapy is not medically appropriate for you)
  - For breast augmentation, the letters must say you have received hormone therapy for at least 2 years and your breasts have barely grown (or describe why hormone therapy is not medically appropriate for you)

IMPORTANT: Your letters should explain WHY the procedure is medically necessary to treat your gender dysphoria. Ask your provider to include SPECIFIC EXAMPLES of how the procedure will help YOU by reducing harmful symptoms you feel.

## Step 2A: Request Prior Approval from Medicaid Managed Care

If you have Medicaid “MANAGED CARE,” you use an insurance company’s card to receive your Medicaid. In NYC, that company could be: AmidaCare, Affinity, Emblem, HealthFirst, HealthPlus, MetroPlus, Fidelis, United HealthCare, or WellCare.



1. Find a surgeon that is in your insurance company’s Medicaid managed care plan network or is willing to contract with your insurance company.
2. Give the two letters to your surgeon. Your surgeon will give the letters to the insurance company and ask for a “prior approval” to perform the procedure and to perform electrolysis (hair removal) as needed for surgery.
3. If your insurance company denies the prior approval, you should receive a written decision within 14 days and up to 28 days if the insurance company asks for an extension to review your case. The denial notice is called an “Initial Adverse Determination.” If you do not receive a decision on your surgeon’s request within 14 days and up to 28 days, than that is the equivalent of a denial and you can request an appeal with your insurance company.
4. Starting, May 1, 2018, you must first file an appeal with your insurance company. This is called an “internal appeal.” You have 60 calendar days to request an internal appeal from the date of the notice. The “Initial Adverse Determination” will have information on how to appeal, but you can always call the member services phone number on the back of your card and say, “I need to request an appeal.” If you request an appeal by phone, the plan will send you something in the mail so you may confirm your appeal request in writing. Please respond.
5. Once you have filed the internal appeal with your insurance company, the insurance company has 30 days to make a decision on this appeal. The insurance company will send you their final decision in writing; if the insurance company denies your request in whole or in part, the decision is called a “Final Adverse Determination.”
6. If this decision denies the prior approval, you can request a different appeal called a fair hearing. If you do not receive a decision on your internal appeal within 30 days, then that is the equivalent of a denial and you can request a fair hearing without waiting to receive the “Final Adverse Determination” notice. You have 120 days from the date on the “Final Adverse Determination” notice to file a fair hearing. Go to <http://otda.ny.gov/hearings/request/> or call 800-342-3334 to request the fair hearing.

## Step 2B: Request Prior Approval from Fee-for-Service Medicaid

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If you have Medicaid “FEE-FOR-SERVICE,” you use a NYS benefits card to receive your Medicaid.



1. Find a surgeon who accepts Medicaid.
2. Give the two letters to your surgeon. Your surgeon will give the letters to Medicaid (the NYS Department of Health) and ask for a “prior approval” to perform the surgery.
3. If Medicaid denies the prior approval, you should receive a decision in writing within 21 days. You can appeal the decision by requesting a “fair hearing” within 60 days of the notice date. Go to <http://otda.ny.gov/hearings/request/> or call 800-342-3334 to request a hearing. If you do not receive a decision on your surgeon’s request within 21 days, then that is the equivalent of a denial and you can request a fair hearing.

To get legal advice or representation,

LSNYC’s LGBTQ  Project can help!

Call (Citywide) 1-917-661-4500 or Email (Bronx only) [LGBTQBronx@lsnyc.org](mailto:LGBTQBronx@lsnyc.org)