HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Dana Flannery, Medicaid Director

Letter of Direction #22

Date: **October 9, 2024**

To: **Turquoise Care Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**

Subject: **Gender Affirming Healthcare**

Title: **Coverage of Gender Affirming Healthcare Medications and Procedures**

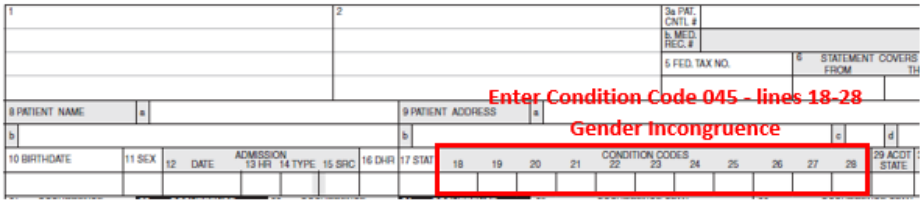
The purpose of this letter of direction is to provide the Turquoise Care (TC) Managed Care Organizations (MCOs) with information on implementing reimbursement for gender affirming healthcare **effective October 1, 2024**

In the 2023 legislative session, the New Mexico legislature passed House Bill 7 codifying access to both abortion and gender affirming healthcare. This letter of direction is to provide guidance and clarification as to what constitutes medically necessary gender affirming healthcare.

1. **Member Eligibility Requirements:** MCOs must allow and reimburse services for members with the following requirements. Requirements and indications must be documented in the member's medical record.
    a. Age:
        i. Members twelve years to seventeen years of age are eligible for hormone therapy only.
        ii. Members eighteen years of age and older are eligible for hormone therapy, procedural and surgical interventions.
    b. Members **must** have a diagnosis of gender dysphoria.
        i. F64.2 - Gender identity disorder of childhood (ages 12-17)
        ii. F64.9 - Gender identity disorder, unspecified (ages 18-999)
    c. Members 18 years of age or older undergoing procedural or surgical intervention should be living within their preferred gender (which includes non-binary) for at least a year.

2. **Covered Services:** MCOs **must** allow and reimburse for gender affirming care. Services, depending on age (see eligibility requirements above), include:
    a. Pubertal blockage for youth,
    b. Masculinizing and feminizing hormone therapy,
    c. Facial feminization/masculinization surgery,
    d. Top surgery including chest reduction and breast augmentation,
    e. Bottom surgery including vaginoplasty, hysterectomies, metoidioplasty, and orchiectomy,
    f. Uterine ablation,
    g. Hair removal including electrolysis and laser hair removal, and
    h. Voice and communication training.
3. **Provider Requirements:** New Mexico Medical Assistance Division (MAD) pays for medically necessary health care services furnished by a MAD enrolled medical provider. [NMAC 8.310.3]. Eligible providers are physicians or other qualified health care professionals (Certified Nurse Practitioners, Certified Nurse Specialists & Physician Assistants, Certified Nurse Midwives).
4. **Prior Authorization:** The MCO **may** require a prior authorization.
5. **Billing and Coding:** MCOs **must** reimburse claims that include the following:
    a. All claims **must** include required diagnosis of gender dysphoria,
        i. F64.2 - Gender identity disorder of childhood (ages 12-17), or
        ii. F64.9 - Gender identity disorder, unspecified (ages 18-999).
    b. Services billed on a UB-04 **must** include condition code 45: Gender incongruence,

    Note: Effective July 1, 2023, the National Uniform Billing Committee revised Condition Code 45 to Gender Incongruence, defined as "characterized by a marked and persistent incongruence between an individual's experienced gender and sex at birth."



    c. Providers **must** use approved gender affirming procedure codes. Please see the approved list in Attachment 1: Table 1: Gender Affirming Procedure Codes. HCA intends to update Table 1 periodically with a goal to include services equally covered for both gender transitions. MCOs, providers, and members may request to add new/existing codes by using the email address MADInfo.HCA@hca.nm.gov.

i. Procedure codes for gender affirming services **must** append modifier KX: services administered to transgender, ambiguous gender, or hermaphrodite patients,

ii. In addition to the codes in Table 1, MCOs will continue to reimburse for psychological services, including but not limited to psychotherapy, social therapy, and family counseling are covered benefits for all ages.

d. Denials for gender affirming procedures will go through the routine claims process with the MCOs, however, the MCO's review for denial must be by a physician(s) or clinician(s) that have at least two years of experience providing gender affirming care.

e. MCOs are required to reimburse the fee schedule rates at a minimum. Gender affirming procedure rates are found in the fee schedule at Fee Schedules - New Mexico Health Care Authority (nm.gov).

6. The MCOs must allow and reimburse providers who have met the requirements and provide gender affirming services from October 1, 2024. MCOs are directed to implement changes associated with these instructions, including system changes and provider contract negotiations as needed, no later than 90 days from the date of issuance of this directive. Health Care Authority (HCA) directs the MCOs to provide biweekly updates to HCA on the status of implementation beginning October 11, 2024

For questions regarding this guidance, please contact the Medical Assistance Division, Benefits and Reimbursement Bureau, at madinfo.hca@hca.nm.gov

This LOD will sunset upon inclusion in NMAC 8.308.9 and the Managed Care Policy.

Attachment 1

Table 1: NM Approved Gender Affirming Procedure Codes

CODE	**DESCRIPTION**
CPT/HCPCS Codes Group 1:	**Transwoman procedures (male to female)**
19325	BREAST AUGMENTATION WITH IMPLANT
54125	AMPUTATION OF PENIS; COMPLETE
54520	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR WITHOUT TESTICULAR PROSTHESIS, SCROTAL OR INGUINAL APPROACH
54690	LAPAROSCOPY, SURGICAL; ORCHIECTOMY
55866	LAPAROSCOPY, SURGICAL PROSTATECTOMY, RETROPUBIC RADICAL, INCLUDING NERVE SPARING, INCLUDES ROBOTIC ASSISTANCE, WHEN PERFORMED
55970	INTERSEX SURGERY; MALE TO FEMALE
56800	PLASTIC REPAIR OF INTROITUS
56805	CLITOROPLASTY FOR INTERSEX STATE

57291	CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT
57292	CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT
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
CPT/HCPCS Codes Group 2:	**Transman procedures (female to male)**
19303	MASTECTOMY, SIMPLE, COMPLETE
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
54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)
55175	SCROTOPLASTY; SIMPLE
55180	SCROTOPLASTY; COMPLICATED
55980	INTERSEX SURGERY; FEMALE TO MALE
56625	VULVECTOMY SIMPLE; COMPLETE
57106	VAGINECTOMY, PARTIAL REMOVAL OF VAGINAL WALL;
57110	VAGINECTOMY, COMPLETE REMOVAL OF VAGINAL WALL;
58150	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S);
58180	SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S)
58260	VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58262	VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S), AND/OR OVARY(S)
58275	VAGINAL HYSTERECTOMY, WITH TOTAL OR PARTIAL VAGINECTOMY;
58290	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58291	VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)

58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58550	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58552	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58553	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58554	LAPAROSCOPY, SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58570	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58571	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58572	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58573	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58720	SALPINGO-OOPHORECTOMY, COMPLETE OR PARTIAL, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)
CPT/HCPCS Codes Group 3:	Other procedure codes
15820	BLEPHAROPLASTY, LOWER EYELID;
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
15822	BLEPHAROPLASTY, UPPER EYELID;
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID
21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, 2 OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)
21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)

21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL
21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)
21137	REDUCTION FOREHEAD; CONTOURING ONLY
21138	REDUCTION FOREHEAD; CONTOURING AND APPLICATION OF PROSTHETIC MATERIAL OR
21139	REDUCTION FOREHEAD; CONTOURING AND SETBACK OF ANTERIOR FRONTAL SINUS WAL
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTH
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)
31599	Other procedure on voice box

This LOD will sunset upon inclusion in 8.308.9 NMAC, Managed Care Program.