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THE DETERMINATION OF MEDICAL NECESSITY: MEDICAID FUNDING FOR SEX-REASSIGNMENT SURGERY

The question of whether the cost of sex-reassignment surgery can be funded under Medicaid is largely dependent on a determination of the medical necessity of the procedure. Although the Medicaid statutory scheme places this responsibility on Professional Standards Review Organizations (PSROs), reviewing courts often ignore this mandate and instead rely upon the treating physician's opinion. This Note articulates the appropriate statutory approach to the medical necessity determination, and criticizes the judiciary's failure to follow the statute. The Note then examines whether sex-reassignment surgery should receive Medicaid funding. In view of the limited success of surgery and recent findings of success with psychotherapy, the Note concludes that PSROs should find the surgery not medically necessary and thus ineligible for Medicaid subsidization.

INTRODUCTION

ALTHOUGH ADVANCES in medical technology may solve complex health problems, they often create equally complex legal problems. For example, the development and availability of relatively safe abortion procedures have forced courts to weigh a woman's right to choose what she does with her body against the state's interest in protecting the potential life of the fetus. Similarly, legislatures and the judiciary have grappled with the legal problems which flow from the ability of doctors to change an individual's anatomical sex to conform to that individual's psychological sex by means of sex-reassignment surgery.

Though sex-reassignment surgery may be performed legally in the United States, laws governing sexual conduct (sodomy), civil records, name changes, birth certificates, marriage and divorce, and employment discrimination all impact upon the life of a transsexual. The majority of these laws pre-date the advent of

1. See Roe v. Wade, 410 U.S. 113 (1973) (where the Supreme Court concluded, in its landmark decision, that a woman's right to privacy includes the right to terminate her pregnancy up to the second trimester of the gestation period).
2. See text accompanying notes 105-10 infra for a description of the procedure involved in sex-reassignment surgery.
3. The procedure is legal in that it is not prohibited in any jurisdiction. See Note, The Law and Transsexualism: A Faltering Response to a Conceptual Dilemma, 7 Conn. L. Rev. 288 (1975). While the author notes that a surgeon may commit mayhem by performing the operation, he concludes there is little chance that criminal liability will be imposed. Id. at 295. But see Comment, Transsexualism, Sex Reassignment Surgery and the Law, 56 Cornell L. Rev. 962, 979-89 (1971).
sex-reassignment surgery and have not been revised to meet the special problems facing the transsexual. One specific aspect of transsexualism to which the law has responded is the cost of sex-reassignment surgery. Because the operation alone may cost over $10,000, most candidates for the surgery cannot afford the expense. Furthermore, since most of the financially independent transsexual Americans' operations are performed abroad, the individuals that desire to undergo the procedure in the United States are, relatively speaking, financially needy. Consequently, many of these transsexuals turn to the federal Medicaid program for financial assistance.

The Medicaid program, title XIX of the Social Security Act, was enacted in 1965 to provide partial federal funding of the costs of medical services for those "whose income and resources are insufficient to meet the costs" of such services. While the statutory scheme empowers the states to decide which medical services will receive funding under the state's Medicaid program, it also limits their power. States may not restrict coverage of any medical treatment which falls within one of the five mandatory service categories unless the state demonstrates either that the treatment is not "medically necessary" or that the use of a particular medical procedure in a specific case is cost inefficient. With regard to sex-reassignment surgery, the states have relied on the medical necessity prong of this two part exception to deny funding.

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4. One observer has catalogued the law which is in need of revision, including the criminal law, Note, supra note 3, at 295-98; name change procedures, id. at 299-300; reissuance of birth certificates, id. at 280-310; civil records, id. at 310-11; marriage and divorce law, id. at 311-24; employment discrimination law, id. at 328-32. See also Note, Transsexuals in Limbo: The Search for a Legal Definition, 31 MD. L. REV. 236 (1971); Comment, supra note 3.


7. Id. at 247.


9. See notes 20-34 infra and accompanying text.

10. See text accompanying note 27 infra.

11. See notes 82-94 infra and accompanying text.

12. States typically deny funding for sex-reassignment surgery by simply classifying the procedure as a noncovered service in the state Medicaid plan. For example, in Ohio, the Medicaid Provider's Handbook, an outgrowth of the Ohio State Medicaid Plan, provides that some medical procedures are not reimbursable or are reimbursable only if certain prerequisites are met. One such category of procedures is "[c]osmetic procedures when
Disputes over funding of sex-reassignment surgery focus largely on the definitional boundaries of medical necessity.\textsuperscript{13} This Note contends that the Medicaid statutory scheme places the responsibility for defining medical necessity and determining which medical services fit within that definition exclusively in the hands of Professional Standards Review Organizations (PSROs).\textsuperscript{14} This Note further contends that once a service is deemed to be medically necessary by a PSRO, the state may still restrict funding for that service but may do so only if it can establish the existence of substantial state fiscal concerns. Such restrictions must be implemented through systematic state PSRO monitoring procedures established by federal regulation.\textsuperscript{15}

PSROs and the courts which review PSRO determinations must decide whether sex-reassignment surgery is medically necessary. This determination usually settles the issue of subsidization by Medicaid. Although the courts have addressed the issue of Medicaid reimbursement for sex-reassignment surgery, they have done so without considering the impact of the PSRO system on the state agency's power to establish limitations. This Note discusses and criticizes the case development, and urges that the courts reevaluate the Medicaid statutory framework in light of PSRO authority.\textsuperscript{16}

The Note then analyzes the question of whether sex-reassignment surgery is medically necessary when scrutinized under the statutory definition of that concept.\textsuperscript{17} An examination of the nature of transsexualism reveals that surgery is not the only available means of treatment,\textsuperscript{18} and that psychotherapy may be a more efficacious form of treatment.\textsuperscript{19} Consequently, the Note concludes

surgery is for aesthetic purposes only. Examples include . . . sex change . . . .'' Ohio Dept. of Public Welfare Medical Handbook Update, No. 2, § 403 (Dec. 1977).

Although the federal Medicare statute categorically excludes funding for cosmetic surgery, 42 U.S.C. § 1395y(a)(10) (1976), there is no similar exclusion in the Medicaid statutory framework. States have, nevertheless, attempted to exclude procedures from Medicaid reimbursement by defining them as cosmetic. See, e.g., G.B. v. Lackner, 80 Cal. App. 3d 64, 145 Cal. Rptr. 555 (1978), where the director of the California Board of Health attempted to deny Medicaid benefits to a transsexual who had undergone sex-reassignment surgery based upon his determination that the surgical procedure was cosmetic.

\textsuperscript{13} See notes 142–98 infra and accompanying text.
\textsuperscript{14} See notes 40–49 infra and accompanying text.
\textsuperscript{15} See notes 71–92 infra and accompanying text.
\textsuperscript{16} See notes 142–98 infra and accompanying text.
\textsuperscript{17} See notes 101–41 infra and accompanying text.
\textsuperscript{18} See notes 101–31 infra and accompanying text.
\textsuperscript{19} See notes 118–31 infra and accompanying text.
that sex-reassignment surgery is not medically necessary and is therefore not entitled to Medicaid coverage.

I. MEDICAID

A. The Statutory Scheme

Medicaid is a cooperative venture between the state and federal governments. If a state submits a Medicaid plan which conforms to federal statutory requirements, as determined by the Secretary of Health and Human Services (H.H.S.)\(^2\) the federal government will pay up to sixty percent of the cost of medical services provided under the program.\(^2\)

Two groups of individuals are eligible to receive Medicaid funds: the categorically needy and the medically needy. Categorically needy individuals are persons "receiving aid or assistance under any plan of the State approved under [subchapters which set minimum income level requirements for eligibility], or with respect to whom supplemental security income benefits are being paid . . . ."\(^2\)

The medically needy category, on the other hand, is comprised of those individuals who are unable to meet the income requirements to qualify for public assistance and yet cannot afford necessary medical care.\(^2\)

A person seeking Medicaid benefits must meet the threshold eligibility requirement under one or both standards before his or her claims to Medicaid assistance can be considered. Since most candidates for sex-reassignment surgery cannot afford its cost, they are likely to be at least medically needy and perhaps even categorically needy. Thus, initial eligibility is ordinarily not the transsexual's main concern. The problem arises when the state determines whether the requested treatment, sex-reassignment surgery, is within the scope of Medicaid coverage.

There is no single section of title XIX that provides a definitive resolution of scope of coverage questions. If there were, the character of the Medicaid program would be fundamentally different. Rather than being a cooperative undertaking in which both state and federal concerns are reflected, Medicaid would be simply a

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\(^2\) 42 U.S.C. § 1396a(a)(1)–(40) (1976). The state pays a minimum of 40%.

\(^2\) Id. § 1396a(a)(10)(A).

\(^2\) Id. § 1396a(a)(10)(C).
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federal program administered at the state level. Such was not the intention of Congress when it drafted title XIX.

Congress intended to reserve a degree of discretion for the states concerning the type and extent to which certain services will be covered. In the preamble to title XIX Congress authorized appropriations "[f]or the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish . . . medical assistance on behalf of . . . individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . ."24 Thus, the preamble sets forth two criteria upon which scope of coverage determinations should be made: services must be practicable under the unique conditions of that state, and they must be for "necessary medical services." Although the preamble does not specify whether the federal or state government is to determine the boundaries of "necessary medical services," it is clearly the state government that is to assess state conditions.

Section 1396a(a)(17) also demonstrates the congressional intent to give states some discretion over scope of coverage determinations. It requires state plans to "include reasonable standards . . . for determining the extent of medical assistance under the plan . . . ."25 Furthermore, this section provides that the standards developed must be consistent with the objectives of title XIX.26

Notwithstanding this broad language, the states' discretion is limited; the statute provides certain minimum guidelines that must be followed. For instance, the statute establishes five categories of services which are required to be covered. Those services include inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing facility services, early and periodic screening, diagnosis, and treatment of individuals under twenty-one, family planning services, and physicians' services.27 States are further circumscribed in their discretion with respect to these mandatory categories by the statutory mandate that each service must be sufficiently subsidized in amount, duration, and scope to achieve its medical or social purpose.28 Finally, and perhaps most importantly for transsexuals,29

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24. Id. § 1396.
25. Id. § 1396a(a)(17).
26. Id.
27. Id. § 1396a(a)(13)(B).
the Medicaid agency may not deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.30

On balance, the statutory scheme limits the states' discretion with regard to scope of coverage determinations. Nevertheless, the preamble of the Act31 allows states to limit the scope of Medicaid coverage if a service is not medically necessary32 or if a state's fiscal concerns, as expressed by means of a state monitoring plan,33 require such limitations.34

B. Medical Necessity

A state's power to limit Medicaid coverage based upon medical necessity is derived from the statutory provision which states that payment for health care services will be made only when, and to the extent that, such services are medically necessary.35 Because the relevant statutory framework does not define precisely what is meant by medical necessity, much litigation on the issue has resulted.36 The statutory framework does, however, provide some guidance.37 Even more importantly, the scheme explicitly provides the mechanism for making medical necessity determinations.38 Nevertheless, in defining medical necessity, courts have consistently ignored these statutory directives and have thus unnecessarily confused the state of the law and have focused primarily on the treating physician's determination in the individual case.39 Reliance on the physician, however, is misplaced because

29. See notes 169, 191–96 infra and accompanying text.
31. See text accompanying note 24 supra.
32. See notes 35–70 infra and accompanying text.
33. 42 U.S.C.A. § 1320c–20(d) (West Supp. 1979). Before the implementation of the PSRO system, states had the authority to conduct review of the operation of Medicaid through utilization review, utilization control, and independent professional review (IPR) activities. Where PSROs have assumed full authority, however, PSRO review performs these activities. Thus, where a PSRO is in operation, states no longer are responsible for conducting utilization or IPR activities. 42 C.F.R. § 463.27(a) (1979).
34. See notes 85–92 infra and accompanying text.
37. See notes 50–60 infra and accompanying text.
39. See notes 142–98 infra and accompanying text.
the statute unambiguously places the responsibility for making such a determination on Professional Standards Review Organizations (PSROs). 40

By approving care as medically necessary on a case-by-case basis, PSROs authorize those services to be federally subsidized. Alternatively, by disapproving care, PSROs bar the federal subsidy. 41 Moreover, the statute names the PSRO as the final arbiter for purposes of determining medical necessity:

[It is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under [the Social Security Act] will conform to appropriate professional standards for the provision of health care and that payment for such services will be made—(1) only when, and to the extent, medically necessary . . . . 42

The regulations regarding the conclusive effect of PSRO determinations on claims for payment explicitly state that no federal funds shall be used to subsidize the cost of services if the PSRO has disapproved of the services giving rise to the claim. 43 Significantly, the regulations also state that a Medicaid state agency may not deny payment on the grounds that the services were not medically necessary unless the services at issue have been disapproved by the PSRO. 44

Contrary to the conclusion reached by many courts, 45 determinations of medical necessity made by a treating physician are not binding upon state agencies reviewing for medical necessity in the Medicaid context. Indeed, the role of the treating physician in Medicaid review is narrowly circumscribed by explicit language in the statute: "No physician shall be permitted to review—(A) health care services provided to a patient if he was directly responsible for providing such services . . . . " 46

40. A PSRO is a nonprofit professional organization of physicians to which the Secretary of H.H.S. delegates review responsibility. 42 C.F.R. § 462.4(a) (1979). Membership in a PSRO is voluntary and open to all doctors of medicine and osteopathy, id. § 462.4(a)(3), but at least 25% of all physicians within the area must be members. Id. § 462A(a)(4).
42. Id.
44. Id. § 463.16(c)(1).
45. See note 150 infra and accompanying text.
46. 42 U.S.C.A. § 1320c-4(a)(6)(A) (West Supp. 1979). Naturally, physicians make determinations on the medical necessity of treatments for their patients every day. This section of title XIX is not intended to inhibit that process in any way; only if a patient seeks federal Medicaid reimbursement will a PSRO reassess the physician's determination and only for the purpose of determining Medicaid coverage.
PSRO review authority is activated at the moment that an individual patient applies for admission to a hospital or other health care facility. The evaluation is usually made on a case-by-case basis, but PSROs are required to develop records based on prior admissions to identify types of cases eligible for automatic certification of admission under the Medicaid program. The development of this data provides the PSRO with the opportunity to save considerable time which would otherwise be wasted in making a detailed review of cases which are consistently found to be medically necessary. A PSRO may also choose to conduct preadmission review of the medical necessity of certain types of health care services.

The fundamental standard by which a PSRO guides its decision on medical necessity is the professionally established norm of care, diagnosis, and treatment. According to the statute, norms must take into account differing but acceptable modes of treatment which are considered "within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care." The regulations amplify the norms concept by defining norms as "numerical or statistical measures of average observed performance in the delivery of health care services."

While the statute refers only to norms of treatment, the regulations require PSRO review to be based on norms, criteria, and standards. The regulations define criteria as "predetermined elements of health care, developed by health professionals . . . with which aspects of the quality, medical necessity, and appropriateness of a health care service may be compared." Standards are defined as "professionally developed expressions of the range of acceptable variation from a norm or criterion."

Some ambiguity is created by the use in the regulations of factors which do not appear in the statute. For example, if professional norms are considered to be merely a "codification of
existing practice,” 56 PSROs would then simply compare a requested form of treatment with this “code” of procedure to determine whether that treatment was medically necessary. This type of limited comparison would never analyze the quality of care being generated by the code. 57 Criteria, on the other hand, consist of a checklist of “state-of-the-art” elements of treatment as determined by selected medical experts 58 and must specify the types of services which are “most effectively, economically, and appropriately provided at a hospital level of care.” 59 The use of criteria would therefore require the PSRO to perform more than a mere survey of the current practice of doctors as the reliance on norms alone suggests. The PSRO would instead compare the requested treatment with the independently developed “ideal” treatment for that illness established by the criteria. The use of criteria therefore creates the possibility that a PSRO could determine that a service is not medically necessary even though a survey of general medical practice might indicate that the service is considered medically necessary. 60 Specifically, this result will occur if the average observed performance of doctors in the community is not in accordance with what is considered by experts to be ideal performance.

Applying the evaluative procedure mandated by the regulations—norms, standards, and criteria—a PSRO defines medical necessity in the following way. The physician recommending hos-

57. The PSRO statute grants conditional immunity to physicians from civil malpractice liability resulting from any actions taken by the physician “in compliance with or reliance upon professionally developed norms of care and treatment . . . ” applied by a PSRO. 42 U.S.C. § 1320c–16(c) (1976). This immunity is conditioned upon the physician’s adherence to the general standards of care. Id. § 1320c–16(c)(2). Because norms are based upon typical patterns of practice within a PSRO region, they could embody the traditional tort standard of care governing the physician-patient relationship. PSRO norms then might supplant the malpractice standards regarding the choice of treatment procedures which have been developed through the common law of any particular jurisdiction. However, because the statutory immunity is conditioned upon the physician’s exercising due care, the malpractice action as an evaluation of medical treatment will not be preempted.


58. See text accompanying note 54 supra.
60. The reverse is also true.
Hospital admission first presents the PSRO with the patient's medical record, along with the reasons the physician considers admission for this treatment necessary. The PSRO compares the data presented by the treating physician with its norms, criteria, and standards, and then determines whether the treatment requested for the set of symptoms presented is within the established criteria. Any quantifiable aspects of the requested treatment, such as the length of a hospital stay, are determined by the norms for that treatment. The PSRO might find, for example, that the requested treatment satisfies the criteria because it is an effective, economical, and appropriate form of treatment for the patient's symptomology. The PSRO determines which laboratory tests are required by the criteria and the total number of days that the norms indicate are necessary for completion of the treatment. If the PSRO has developed standards, it would indicate to the physician the range of acceptable procedures in giving a particular form of treatment, and perhaps a range of days within which the treatment should be completed. If, on the other hand, the norms and criteria did not indicate the treatment requested for the given symptomology, the PSRO would deem the treatment to be not medically necessary and, as a result, the service requested could not receive federal financial support under Medicaid.

A medically necessary service in the Medicaid context is therefore one which a PSRO determines to be within the range of appropriate treatment presently offered by health professionals for a particular illness or condition. Norms of care set the boundaries for that range, but the requested service must also be effective, economical, and appropriate to satisfy criteria. A treating doc-

61. A PSRO determination which results in the denial of Medicaid benefits may be appealed by the claimant. See text accompanying notes 65–70 infra.

62. A PSRO could deviate from this standard procedure. First, a PSRO could use variant norms. The statute allows a PSRO to apply a norm which is different from the regional norm of care if there is a "reasonable basis for usage of other norms in the area concerned . . . " 42 U.S.C. § 1320c–5(a) (1976). This provision permits the application of local norms of care for particular services if the PSRO determines that "[t]he patterns of practice in those locations and hospitals are substantially different from patterns in the remainder of the PSRO area; and (2) there is a reasonable basis for the difference which makes the variation appropriate." 42 C.F.R. § 466.50(b)(1)–(2) (1979). The impact of allowing the use of variant norms is that norms may be different from hospital to hospital or community to community. Nevertheless because norms must still be consulted, PSROs are not at liberty to accept or deny a service without going through the appropriate procedural steps.

The second way a PSRO might deviate from this procedure is by arguing that norms, criteria, and standards are not the exclusive means by which to judge medical necessity. The argument would be based upon the statutory language which states that PSROs must
tor may not directly participate in the PSRO evaluation of medical necessity due to the conflict of interest between his or her PSRO responsibilities and the possible financial benefit which might flow from the decision. The doctor can indirectly influence the PSRO's ultimate decision, however, by contributing to the formulation of the general standard of care for the community. In addition, the attending physician must be given the opportunity to discuss with the PSRO the nature of the patient's need for health care services, before the PSRO concludes that a service is not medically necessary.

If a potential recipient of funds is dissatisfied with a PSRO determination, he or she may utilize the statutory hearing and review process, which includes a reconsideration of the claim by the local PSRO. If the local PSRO affirms its prior decision, and the matter in controversy exceeds $100, the individual's request is entitled to review by the Statewide Professional Standards Review Council. If the decision of the Statewide Council is adverse to the claimant, the individual is then entitled to a hearing by the Secretary of H.H.S. Should the claimant still be dissatisfied with the decision, review by a United States District Court may be obtained where the amount in controversy is $1000 or more. Notably, a state Medicaid agency has no similar right to judicial review of a medical necessity determination if the PSRO concludes that a

apply norms "as principal points of evaluation and review." 42 U.S.C. § 1320c-5(a) (1976). Since the statute does not explicitly rule out other methods, a PSRO could argue that it is free to use any other means it deems appropriate to decide medical necessity. The argument fails, however, because it compels the conclusion that there are absolutely no federal or state controls on medical necessity determinations. Such a conclusion directly contradicts the legislative scheme and intent. The extensive regulations which define norms, criteria, and standards would be nugatory in the face of such an assertion. Finally, the argument also raises the possibility of runaway PSROs, making medical necessity evaluations which are not based upon statutory authority and which are essentially unreviewable.

63. See note 46 supra.
64. 42 C.F.R. § 466.10(e)(1)-(2) (1979).
65. 42 U.S.C. § 1396a(a)(3) (1976). This review and appeal process is in lieu of any other appeals procedure provided by the Social Security Act. Id. § 1320c-8(c).
66. Id. § 1320c-8(a).
67. Id. § 1320c-8(b). The Statewide Council is composed of one representative from each PSRO in the state, four physicians designated by the state medical society and the state hospital association, and four persons selected by the Secretary of H.H.S. as representatives of the public. Id. § 1320c-11(b)(1)-(3).
68. Id. § 1320c-8(b).
69. Id. § 1320c-8(b). The Act further requires that findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive in any court proceeding. Id. § 405(g). The statutory framework reflects the legislative intent to limit the scope of judicial review of the determination of medical necessity.
claimant is entitled to Medicaid benefits.\textsuperscript{70}

C. State PSRO Monitoring

A state may control the scope of Medicaid coverage on the basis of the medical necessity of a requested service and the impact on the total state Medicaid expenditure of providing a requested service.\textsuperscript{71} Due to the binding effect of PSRO determinations, however, a state's freedom to shape coverage boundaries through the medical necessity rationale is severely limited. Nevertheless, it is evident that Congress intended the states to retain some degree of control over which services they will fund. The "as far as practicable" language in the preamble,\textsuperscript{72} as well as the authorization to limit the amount, duration, and scope of services consistent with the objectives of title XIX,\textsuperscript{73} manifest the congressional intention that states' legitimate fiscal concerns be accommodated.

There is, moreover, additional support for the proposition that Congress intended the states to be able to limit coverage on the basis of state fiscal concerns. Section 1903(e) of the original Social Security Act required states to broaden the scope of covered services so that all eligible individuals would receive comprehensive medical care by 1977.\textsuperscript{74} Congress repealed section 1903(e) in 1972,\textsuperscript{75} stating that "since 1965 . . . health care costs [have risen] . . . .\textsuperscript{76}"

\textsuperscript{70} The PSRO statutory framework has survived constitutional attack. In Association of Am. Physicians and Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill.), aff'd, 423 U.S. 975 (1975), the court held that the PSRO legislation did not unconstitutionally interfere with a physician's right to practice, nor was it arbitrary or lacking in justification, id. at 132, unconstitutionally overbroad, id. at 134, an unconstitutional interference with the physician-patient relationship, id. at 135, unconstitutionally vague, id. at 138, an unconstitutional imposition of civil liability upon plaintiffs, id. at 139, an unconstitutional creation of presumptions inconsistent with presumptions of competence, good moral character, and regularity of motive and conduct inherent in medical licensure, id., or an unconstitutional empowering of biased private organizations to exercise quasi-judicial authority, id. at 140. Additionally, the court held that the PSRO enabling legislation did not infringe upon the right of privacy of doctors and their patients as guaranteed by the first, fourth, fifth, and ninth amendments. Id. at 137.

\textsuperscript{71} See notes 35–38 supra and accompanying text.

\textsuperscript{72} See note 24 supra and accompanying text.

\textsuperscript{73} See notes 28–30 supra and accompanying text.


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far beyond anything envisaged when section 1903(e) was enacted [and consequently] the mandatory aspect of that section has created an almost fiscally unbearable burden in many States."

The original Social Security Act also contained a provision which prohibited a state from reducing the extent of care and services provided under its plan if the modification would cause a reduction in the total state Medicaid expenditure from one year to the next. After expressing concern about the provision's restrictive effects on the states' ability to meet fiscal crises, Congress repealed this section of the Act in 1972. Consequently, states are now able to modify the scope and extent of optional services consonant with the state's fiscal policy.

The repeal of these sections illustrates congressional awareness of and concern for state fiscal interests, but, the question remains as to where the fiscal element enters into scope of coverage determinations. Because PSROs consider the economic as well as the medical aspects of the requested treatment, state review of PSRO evaluations necessarily encompasses a review of the economic issues. Thus, fiscal concerns are reflected in state PSRO monitoring procedures.

Section 1320c-20(d)(1) of title XIX authorizes state Medicaid agencies to monitor the performance of PSROs within the state. If a state chooses to exercise its review capability, it must submit a state monitoring plan, including the standards which will be used to evaluate PSRO performance to the Secretary of H.H.S. If the Secretary approves the plan, the state may begin to evaluate the effects of PSRO review on the total state Medicaid expenditure and the appropriateness of care received by individuals seeking Medicaid benefits. The state may also review the general performance and effectiveness of the PSRO.

81. See note 59 supra and accompanying text.
83. Id. § 1320c-20(d)(1)-(2).
84. Id. § 1320c-20(d)(3)(A).
If the monitoring agency finds any PSRO activity which is ineffective or which adversely impacts upon appropriateness of care or total state Medicaid expenditures, it may exercise one of two options. First, the monitoring agency may choose to meet with the PSRO to discuss methods for correcting the defect.\textsuperscript{85} If it elects to hold such a meeting, the monitoring agency must notify the Secretary of H.H.S. of any serious problems and of the outcome of the meeting.\textsuperscript{86} The Secretary may then decide to take appropriate action.\textsuperscript{87} The monitoring agency's second option is to request the Secretary to compel the PSRO to take corrective action, or to suspend the PSRO's authority to make conclusive determinations for purposes of payment under Medicaid.\textsuperscript{88} Should the Secretary suspend the PSRO's authority, the PSRO must continue its review activity, but its determinations will only be advisory to the Medicaid state agency.\textsuperscript{89}

The second option may be exercised only under narrowly circumscribed conditions. The state monitoring agency must present to the Secretary reasonable documentation which shows that the PSRO has caused "an unreasonable and detrimental impact on total State expenditures under . . . [Medicaid] and on the appropriateness of care received by individuals" under the state's Medicaid plan.\textsuperscript{90} Only when such documentation is produced, and only when it demonstrates that the detrimental impact has been caused solely by the PSRO, will the Secretary review the PSRO's activities.\textsuperscript{91} Finally, if the Secretary undertakes to review the PSRO's activities, any action taken to restrict PSRO authority is final and not subject to judicial review.\textsuperscript{92}

The ability of a state to conduct PSRO monitoring has a profound impact upon the administration of the Medicaid program. Specifically, a state monitoring agency's ability to challenge PSRO determinations on the basis of fiscal concerns allows states to limit the scope of Medicaid coverage based on their peculiar economic conditions.\textsuperscript{93} Furthermore, because the Secretary can

\textsuperscript{85} 42 C.F.R. § 463.10(e)(1)(i) (1979).
\textsuperscript{86} Id. § 463.10(e)(1)(ii).
\textsuperscript{87} Id. § 463.10(e)(2). The Secretary could choose to suspend the PSRO's review authority.
\textsuperscript{89} 42 C.F.R. § 463.10(e)(1)–(2) (1979).
\textsuperscript{91} 42 C.F.R. § 463.10(d)(2) (1979).
\textsuperscript{93} See notes 74–80 \textit{supra} and accompanying text. The state monitoring agency must
suspend a PSRO's authority to make conclusive determinations on medical necessity based upon a state monitoring agency's petition, a state is not required to fund all procedures deemed medically necessary by a PSRO. If the Secretary has in fact suspended the PSRO's authority, a state Medicaid agency faced with a PSRO decision that a particular service is medically necessary may ignore the PSRO's determination and refuse to fund the service.  

Although the state monitoring provisions give the states the potential to disregard PSRO decisions under some circumstances, the same provisions impose a significant limitation on that power. The Secretary's decision not to suspend a PSRO's authority is not reviewable in the courts. Thus the states are statutorily barred from raising their state fiscal concerns in a court action seeking to overrule a PSRO determination of medical necessity. The Medicaid statutory scheme affords judicial review solely to aggrieved claimants. If a state wishes to limit the scope of Medicaid services on the basis of fiscal concerns it must pursue the administrative remedies provided under the state PSRO monitoring provisions.

II. GENDER DYSPHORIA

In order to receive Medicaid funding, a candidate for sex-reassignment surgery must first meet the eligibility requirements of Medicaid. If the individual is eligible, the state Medicaid agency determines whether the surgery falls within the five mandatory service categories. If the treatment is not statutorily excluded, the PSRO rules on the treatment's medical necessity. Only if the treatment is medically necessary may the state provide funding.

It is at the final stage in this procedure that sex-reassignment

base its objection on both fiscal concerns and the negative impact on the appropriateness of care. However, if the PSRO has caused a misallocation of resources, some individuals in the system are arguably being used elsewhere. It seems logical, therefore, that whenever a state can demonstrate a serious negative impact on state fiscal resources, it can also demonstrate a corresponding decline in the appropriateness of care received systemwide.

94. The state may also find that the PSRO was correct and that the service was indeed medically necessary. In either event, neither the statute nor the regulations indicates how the state is to make the medical necessity determination. Under these circumstances, however, it is likely that a state would revert back to utilization control or review procedures. See 42 C.F.R. § 463.10(e)(3) (1979).
95. See notes 22-23 supra and accompanying text.
96. See note 27 supra and accompanying text. Sex-reassignment surgery falls within these requirements.
97. See notes 35-64 supra and accompanying text.
surgery has been deemed inappropriate. States have argued that sex-reassignment surgery is not medically necessary and is therefore nonreimbursable.\footnote{See Rush v. Parham, 625 F.2d 1150 (5th Cir. 1980).} They have also attempted to justify exclusion of sex-reassignment surgery on the basis of fiscal concerns, reasoning that the funding of such surgery would have a detrimental impact on the state Medicaid budget.\footnote{See Brief for State Appellant at 26–28, Rush v. Parham, 625 F.2d 1150 (5th Cir. 1980). Although a state may seek to exclude coverage of sex-reassignment surgery because of its adverse impact upon the state's Medicaid budget, it may do so only in accordance with state PSRO monitoring procedures discussed at notes 71–94 supra and accompanying text. Thus, because the state appellant in \textit{Rush} did not raise its fiscal objections in an administrative hearing before the Secretary of H.H.S. as required by 42 U.S.C.A. § 1320c-20(d)(3)(A) (West Supp. 1979), it should be precluded from making this argument before the court.}

This Note focuses on the first justification, medical necessity, by examining the nature of transsexualism (gender dysphoria) and alternative forms of treatment. It concludes that sex-reassignment surgery is medically unnecessary and thus that it should not be federally subsidized by Medicaid.

A. The Nature of Gender Dysphoria

Although psychological definitions of transsexualism differ to some degree, they are, for the most part, quite similar. A transsexual is a person who expresses an intense desire to be of the opposite sex. Behavior of this type is called gender dysphoria.\footnote{Twardy, \textit{Medicolegal Aspects of Transsexualism}, 26 MED. TRIAL TECH. Q. 249 (1980).} Transsexuals claim that they are one sex trapped inside a body of the opposite sex. They further claim that their intense depression and suffering can be alleviated only through surgery which transforms their organs to those of the desired sex.\footnote{See generally Lothstein, \textit{Psychodynamics and Sociodynamics of Gender Dysphoric States}, 33 AM. J. PSYCHOTHERAPY 214, 214–16 (1979).}

Although it may appear from this simple set of descriptive criteria that diagnosing transsexualism is a routine matter, the opposite is true. A patient's request for sex-reassignment surgery, while providing the necessary evidence of transsexual symptoms, may not provide sufficient evidence for the actual diagnosis of transsexualism.\footnote{Kirkpatrick & Friedman, \textit{Treatment of Requests for Sex-Change Surgery with Psychotherapy}, 133 AM. J. PSYCH. 1194 (1976).} In fact, such a request might be made by a homosexual transvestite, a paranoid schizophrenic, or persons suffering other serious psychological disorders which are not necessarily
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incident to transsexualism. Furthermore, because psychotherapy is an alternative form of treatment, applicants must be screened so that unnecessary surgery is avoided.

1. Conventional Treatment: Sex-Reassignment Surgery

If transsexualism is diagnosed, sex-reassignment surgery may be chosen for its treatment. Sex-reassignment surgery is a highly complicated, multi-operation procedure. Female-to-male surgery involves primarily the construction of a penis and a scrotum. The ideal outcome of such surgery is the construction of a penis which is psychologically, cosmetically, and physiologically satisfactory. Only the psychological and cosmetic objectives, and the limited physiological objective of the ability to achieve an erec-


104. The screening and diagnosis period usually requires a minimum of one year. During this time, extensive physical and psychiatric testing is performed, and doctors are given the opportunity to observe the patient over a prolonged period to assess the sincerity of the patient's desire to undergo the surgery. Most clinics also require that the patient "cross-dress" and live entirely in the desired sex role for six months to a year. Hastings, supra note 6, at 248-50.

The diagnostic period is lengthy because of the lack of understanding of the origins, or etiology, of the disease. In 1971 Dr. Benjamin wrote,

The entire question of etiology . . . is still open, and so is my own mind about it. From all available evidence in the field of psychology as well as physiology, I feel that no one is justified at this time in saying categorically that transsexuals are made, not born. The opposite may also be true . . . . [M]ore than one cause is probably responsible for the transsexual syndrome.


105. The method used is called the tubed flap method. First employed by Bogoras in 1936, the procedure has been refined by Gillies, Frumkin, and Maltz. Hoopes, Operative Treatment of the Female Transsexual, in TRANSEXUALISM AND SEX REASSIGNMENT 335, 342 (R. Green & J. Money eds. 1969).
tion, however, are even potentially attainable. Notably, attempting to achieve even these limited objectives may result in many complications.

Male-to-female surgery consists of castration and vaginal construction. A variety of methods have been used, involving single-stage and multi-stage procedures. Some patients who have undergone male-to-female sex-reassignment have attained satisfactory results after two to eight years of follow-up care. The postsurgical patients then live their lives in their new gender role.

Not all researchers conducting follow-up studies of sex-reassigned individuals report such uniform success. When follow-up studies first appeared in the literature, most reported excellent results, but the trend has since reflected more qualified success.


107. Id. at 299. The less than ideal outcome of penis reconstruction is due to the complexity of the surgery. Several stages are required to develop a tube, to migrate it to the genital area, to construct a urethra, and to add an os penis as needed.

108. Id. at 301.


110. Markland & Hastings, Vaginal Reconstruction Using Bowel Segments in Male-to-Female Transsexual Patients, 7 ARCHIVES SEXUAL BEHAVIOR 305 (1978). Each of the methods reported has complications associated with it.

111. Id. at 306.

112. Id. at 307.

113. One early researcher, who analyzed the postoperative results of surgery performed on 121 male transsexuals, concluded that a satisfactory outcome of sex-reassignment surgery, in terms of improved social and emotional adjustment, was at least ten times more likely than an unsatisfactory outcome. Pauly, The Current Status of the Change of Sex Operation, 147 J. NERVOUS & MENTAL DISEASE 460 (1968). Another early observer reported on 51 reassigned biological males. H. BENJAMIN, THE TRANSSEXUAL PHENOMENON (1966). He estimated "good" results in 33% (integration into the world of women, acceptance by the family, and reasonable sexual adjustment); "satisfactory" results in 53% (less successful adjustment, although meeting most of the patient's wishes); and "doubtful" results in 10% (appearance and sexual function unsatisfactory, despite some relief from unhappiness). Id. (discussed in Meyer & Reter, Sex Reassignment, 36 ARCHIVES GENERAL PSYCH. 1010, 1010 (1979)).

Randell assessed 29 biological males and six females and reported their postoperative progress after time periods ranging from three months to several years. Randell, Preoperative and Postoperative Status of Male and Female Transsexuals, in TRANSEXUALISM AND SEX REASSIGNMENT 355 (R. Green & J. Money eds. 1969). Five men had shown "psychopathic and antisocial propensities" prior to surgery, and nine had "depressive illness of varying degrees." Three had postsurgical depressive relapses, and two subsequently committed suicide. Comparing preoperative and postoperative adjustment of male patients by means of social and subjective criteria, Randell reported a shift from 86% fair or poor
One of the most recent studies, conducted by J.K. Meyer and D.J. Reter of Johns Hopkins University, departed from the usual practice of reporting on only postsurgical patients and included as a control group subjects who did not undergo the surgery. They compared the groups in the areas of adaptation (e.g., residence, education, job), family relationships, adaptational patterns at major life intervals (e.g., grade school, high school), and fantasies, dreams, and sexual activity. Using the data produced by these observable behavioral variables, they concluded that applicants for sex-reassignment, whether they undergo surgery or not, demonstrate improvement over time. They concluded that sex-reassignment surgery confers no objective advantage in terms of social rehabilitation, although it remains subjectively satisfying to those who have rigorously pursued a trial period and who have undergone it. Significantly, Meyer's conclusion resulted in the abandonment of sex-reassignment surgery at Johns Hopkins University, the hospital which had initiated the procedure in the United States. 

adjustment preoperatively to 72% excellent or good postoperative adjustment. Twenty-two males were satisfied with surgery, six were dissatisfied, and one wished that the reassignment could be reversed. The six females received androgens and subsequently underwent numerous surgical procedures. Results were judged to be excellent in three, good in two, and fair in one. Id. at 355-82.

Money's research focused on the case histories of 24 postoperative subjects. Money & Ehrhardt, Transsexuelle nach Geschlechtswechsel, in TENDENZEN DER SEXUALFORSCHUNG 70 (G. Schmidt, E. Schorsch & V. Sigusch eds. 1970), cited in Comment, supra note 3, at 977. To measure the success of surgery, he examined the patients' expressed satisfaction with the surgery, employment status, police records, psychiatric records, and sexual relationships. All but one unequivocally expressed the feeling of having done the right thing in undergoing reassignment. Nine males improved in employment status and eight remained the same; three females improved in employment status while four remained the same; six of the males had been arrested prior to surgery and two were arrested again postsurgically; none became psychotic, and all showed stability in sexual partnerships.

According to a follow-up study of 25 reassigned males conducted by Hastings, postoperative adjustment averaged between good and fair. Hastings, Postsurgical Adjustments of Male Transsexual Patients, 1 CLINICS PLASTIC SURGERY 335, 335-44 (1974). Adjustment was rated on a four-point scale (from poor to excellent) in each of four major categories: economic, social, sexual, and emotional. Although no patients with known histories of overt mental illness were accepted into the program, two psychotic episodes occurred postoperatively and four patients made serious suicide attempts.

114. Meyer & Reter, supra note 113.
115. Id. at 1015.
116. Id. Meyer has also expressed his personal opinion on the subject: "[S]urgery is not a proper treatment for a psychiatric disorder, and it's clear to me that these patients have severe psychological problems that don't go away following surgery." N.Y. Times, Oct. 2, 1979, § C (Science Times), at 1, col. 1.
117. Id. Precisely what precipitated the abandonment of sex-reassignment surgery at Johns Hopkins is open to some speculation. It has been suggested, however, that the deci-
2. Alternative Treatment: Psychotherapy

Not until recently has psychotherapy been recognized as a potentially successful alternative treatment for transsexualism. In 1973, Dr. Brent reflected the view of a majority of his profession when he stated: "The alternative to surgical rehabilitation is relegation to a life of frustration and despair or suicide." Similarly, Dr. Pauly observed in 1968: "Psychotherapy has not proved helpful in allowing the transsexual to accept that gender identity which is consistent with his [sic] genital anatomy."

Since Dr. Pauly's subsequent assertion in 1969 that there were no reported cases in which psychotherapy had been used successfully, such cases have begun to appear in the literature. In 1979 Dr. Lothstein of Case Western Reserve University Medical School reported successful psychotherapy with transsexuals. He noted that although the variety of group formats makes evaluation and comparison difficult, the success of his group therapy approach "refutes the idea that psychotherapy is useless with gender dysphoric patients."

Psychotherapy is not, however, a treatment without problems. Lothstein reports that gender dysphoric patients often equate psychotherapy with a refusal of surgery. Consequently, the patient views the therapist as a dangerous figure who must be destroyed. Lothstein, however, has surmounted these initial difficulties. He reports that

sion was political rather than scientific. See Lothstein, The Post-Surgical Transsexual: Empirical and Theoretical Considerations, to be published in ARCHIVES SEXUAL BEHAVIOR (Summer 1980).

While agreeing with Dr. Meyer's conclusion that sex-reassignment is palliative and not rehabilitative, Dr. Paul A. Walker, director of the University of Texas gender clinic in Galveston, opined that the surgery should be performed anyway. 20 MEDICAL WORLD NEWS 17, 19 (Sept. 17, 1979). Dr. Chester W. Schmidt, chief of psychiatry at Baltimore City Hospital, defends Dr. Meyer's findings, pointing out that the study appeared in the Archives of General Psychiatry, which is published by the American Medical Association. The appearance of the study there, Schmidt asserts, indicates the A.M.A.'s approval of the study's conclusion. Id.

122. Id.
123. Id. at 77.
124. Id. at 78.
Two male-to-female patients who were compulsively driven to seek sex reassignment surgery, discovered in group meeting that their problems were psychological and left the gender program. Another male-to-female patient was considered an excellent surgical candidate, but after two years of group therapy, he began to experience intense ambivalence and put off scheduling his surgery. Another patient left the group after a brief period after realizing he wished to continue in a homosexual transvestite role.

Similarly, Gilpin, Raza, and Gilpin reported that a disturbed six-year-old boy with transsexual symptoms was successfully treated by a female psychotherapist. It was noted by the researchers that success may depend on the youth of the subject.

Many recent studies have attacked the justifications for sex-reassignment surgery and have supported psychotherapy not only as an alternative but as the preferred treatment. In his recent follow-up study, Lothstein reports that sex-reassigned individuals show moderate to severe psychological dysfunction. In addition, he suggests that major issues, such as the patient's organization, synthesis, and integration of the new gender identity, as well as problems associated with social perceptions, are not and cannot be resolved through sex-reassignment surgery. He concludes that the problems of the postoperative patient are rooted in psychological dysfunctions which cannot be remedied by sex-reassignment surgery, and that psychotherapy may provide the only mechanism for treating most transsexuals.

B. Sex-Reassignment Surgery is Medically Unnecessary

Medical necessity in the Medicaid context is defined in terms

125. Id. at 79 (emphasis omitted).
126. Gilpin, Raza & Gilpin, supra note 104.
127. Id. at 461–62.
129. Lothstein, supra note 117.
130. Id.
131. Id.; see also Lothstein, Expressive Psychotherapy with Gender Dysphoric Patients, to be published in ARCHIVES SEXUAL BEHAVIOR (Summer 1980). Contra, Phillips v. Piotkin, 12 Pa. D. & C. 3d 54 (1979), where a male transsexual petitioned the court to compel his wife to support him during their separation prior to divorce. His wife had refused support due to several violent acts inflicted upon her by her husband which she claimed forced her departure from their home. The court, in deciding that the wife was justified in leaving the home and refusing support, held that the prevailing viewpoint was that transsexuals are psychologically healthy individuals, and that therefore the husband's acts were not compelled by his condition. Id. at 2259–60.
of norms, criteria, and standards.\textsuperscript{132} In order for a requested treatment to meet the established criteria, it must be both effective and appropriate.\textsuperscript{133} The studies by both Meyer and Lothstein indicate, however, that sex-reassignment surgery is neither effective nor appropriate.\textsuperscript{134} The Meyer study expresses serious doubt that the sex-reassigned individual will adjust, psychologically or socially, any better than an individual who does not undergo the surgery;\textsuperscript{135} Lothstein adds that the major psychological problems which cause gender dysphoria are not resolved through sex-reassignment surgery.\textsuperscript{136} Moreover, the frequency of complications after the surgery also supports the conclusion that the surgical procedure is both ineffective and inappropriate for the treatment of gender dysphoria.\textsuperscript{137}

Psychotherapy, though dismissed as a valid technique ten years ago, has recently been demonstrated to be quite effective in the treatment of gender dysphoria.\textsuperscript{138} Not only has it proved valuable as a rehabilitative tool, but it has also been shown to be capable of curing transsexual behavior. Finally, psychotherapy does not carry the inherent risks associated with hormone treatment and surgery, such as cancer, infection, or anesthetic complications.

In light of its apparent success and lack of attendant adverse side effects, psychotherapy should be the preferred treatment for gender dysphoria. Sex-reassignment surgery should, therefore, be deemed medically unnecessary, a determination which bars Medicaid reimbursement.\textsuperscript{139}

A transsexual claimant under Medicaid could appeal a PSRO's determination that sex-reassignment surgery is not medically necessary. If the decisions of the Statewide PSRO and the Secretary of H.H.S. were adverse to the claimant, the issue could then be litigated in federal court. For the court to rule in favor of the claimant, it would have to find that the Secretary's determination was not supported by substantial evidence.\textsuperscript{140} Given the data

\begin{flushleft}
\textsuperscript{132} See notes 53–62 supra and accompanying text.
\textsuperscript{133} See note 59 supra and accompanying text.
\textsuperscript{134} See notes 116, 128–31 supra and accompanying text.
\textsuperscript{135} See notes 114–15 supra and accompanying text.
\textsuperscript{136} See notes 129–30 supra and accompanying text.
\textsuperscript{137} See note 108 supra and accompanying text.
\textsuperscript{138} See notes 118–31 supra and accompanying text.
\textsuperscript{139} See notes 41–43 supra and accompanying text.
\textsuperscript{140} See note 69 supra.
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reported above, it seems unlikely that a court would make that determination.

Though federal courts have ruled on medical necessity issues in the Medicaid context, they have not done so with reference to norms, standards, and criteria. Rather, the courts have inexplicably ignored these statutory guidelines which define medical necessity. A review of the incongruous decisions which have resulted illuminates the desirability of the statutory approach suggested above.141

III. COURT DECISIONS

The courts of appeal are split on the question of whether Medicaid funding should subsidize sex-reassignment surgery. In Rush v. Parham,142 an anatomical male who had been diagnosed as a transsexual by her physician sought Medicaid reimbursement from the Georgia Department of Medical Assistance for the cost of sex-reassignment surgery.143 The Department rescinded its initial approval, stating that the surgery was not covered because it was experimental.144 Rush requested reconsideration and supported her request with affidavits from two experts.145 Although the affidavits stated that Rush was a true transsexual and that sex-reassignment surgery was the only effective means of treatment,146 the Department again rejected Rush’s claim, this time basing its decision upon the newly amended state Medicaid plan which specifically excluded experimental surgery.147 Rush sought injunctive relief in the district court, alleging that Georgia’s refusal to pay for the surgery violated the federal statutory requirement that

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In Doe v. Bolton, 410 U.S. 179, 192 (1973), the Supreme Court noted five factors which it considered to be relevant in evaluating a physician’s decision regarding the necessity of an abortion: “physical, emotional, psychological, familial, and the woman’s age.” This list of factors has been advanced as the Bolton definition of medical necessity. Even if this definition controls, sex-reassignment surgery would remain medically unnecessary because it cannot relieve the psychological distress experienced by the transsexual. See notes 129–31 supra and accompanying text.

142. Rush v. Parham, 625 F.2d 1150 (5th Cir. 1980).
143. Id. at 1152.
144. Id. at 1153.
145. Id.
146. Id.
147. Id.

a state Medicaid program pay for all medically necessary services.  

In granting the plaintiff's motion for summary judgment, 149 the district court held that Georgia's Medicaid program must pay for all medically necessary services, and that the state must not interfere with the determination of medical necessity made by the attending physicians. 150 The court of appeals reversed, stating that

a state may adopt a definition of medical necessity that places reasonable limits on a physician's discretion. One such limitation is the one Georgia contends it used in denying the surgery: a ban against reimbursement for experimental forms of treatment, i.e., not generally recognized as effective by the medical profession. 151

The court further stated that it is within a state Medicaid agency's power to review on a case-by-case basis the medical necessity of prescribed treatment. 152

Significantly, the court did not hold that the state Medicaid agency must provide funding for all services deemed by a treating physician to be medically necessary. 153 It held, instead, that it is the state's responsibility to define medical necessity in a manner consistent with "the requirements of its own Medicaid program"—a definition that may differ from that used by the patient's attending physician. 154

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149. Rush moved for summary judgment on the basis that there was no issue of material fact on the two questions before the court: (1) whether a state Medicaid program could categorically deny funding of a service which two physicians had stated was medically necessary, and (2) whether the Department of Medical Assistance had abused its discretion in finding that the surgery was not required in this instance. Id at 388.

150. Id. at 390.

151. 625 F.2d at 1150.

152. Id. at 1155.

153. In Harris v. McRae, 100 S. Ct. 2671 (1980), the Supreme Court also sidestepped the issue of whether Medicaid must provide funding for all medically necessary services. It held that states could refuse to provide Medicaid reimbursement for services from which Congress has specifically withdrawn federal financial support. Id. at 2684. Thus, states can constitutionally deny funding for medically necessary abortions.

154. 625 F.2d at 1155. By implication, state fiscal concerns may enter into the formulation of the definition.

The court in Rush believed that the standards used by states in defining medical necessity should be analogous to those used in the Medicare program. Id. at 1156. It quoted from a Medicare letter which stated that "a basic consideration is whether the service has come to be generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is being used." Id. The court directed the
Perhaps the most critical fault in the *Rush* court’s analysis was the failure to consider the impact of the PSRO legislation. As a result, even after the court properly found that states do have discretion over what services must be covered, it struggled with the questions of who within the state should create the definition of medical necessity and what standards are to be applied in formulating that definition. The PSRO legislation unambiguously states that PSROs decide medical necessity, and that the definition is to be based upon norms of care as defined by the statute and the regulations. The court, however, without the guidance of section 1320c, stated that the standard of review for an attending physician’s diagnosis is whether the diagnosis was “without any basis in fact.” In so deciding, the court ignored the statutory command that an attending physician not be permitted to participate directly in the medical necessity determination for purposes of Medicaid reimbursement. The court also created a presumption in favor of the attending physician’s determination in contradiction of the PSRO legislation which provides that the attending physician’s determination is only advisory to the PSRO.

In an attempt to find statutory guidance for the formulation of the definition of medical necessity, the court looked to the Medicare program. This choice, however, was an unfortunate one. There are thirteen types of services which are statutorily excluded from coverage under Medicare, one of which is cosmetic surgery. There are no such categorical exclusions in the Medicaid statutory framework. Instead, Congress implemented a comprehensive system for making such determinations on a case-by-case basis and delegated decisionmaking authority and responsibility to PSROs. Thus, by using Medicare standards to formulate similar standards under Medicaid, the court circumvented the entire scheme which Congress established for making medical necessity determinations under Medicaid.

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155. See notes 42–46 supra and accompanying text.  
156. 625 F.2d at 1157.  
157. See notes 46 supra and accompanying text.  
158. See note 64 supra and accompanying text.  
160. Id. § 1395y(a)(10).  
161. See notes 35–94 supra and accompanying text. On remand, the district court should find that it has no jurisdiction to decide whether Georgia’s characterization of sex-
The only other court of appeals which has ruled on Medicaid funding for sex-reassignment surgery reached a contrary result. In *Pinneke v. Preisser*, the county office of the Iowa Department of Social Services refused to fund the sex-reassignment surgery of an eligible applicant. Because the Iowa State Medicaid Plan had established an irrebuttable presumption that treatment of transsexualism by alteration of healthy tissue was not "medically necessary," the Commissioner of the Department affirmed the decision. The District Court for the Northern District of Iowa, however, reversed the Commissioner's decision, holding that the denial of Medicaid benefits for sex-reassignment surgery was contrary to the provisions of title XIX of the Social Security Act and therefore in violation of the supremacy clause of the United States Constitution. The court declared the relevant parts of the Iowa State Plan void and permanently enjoined the Iowa Medicaid program from refusing to fund the surgery.

In affirming the decision of the district court, the court of appeals relied on four findings. First, the court accepted medical testimony and documentary evidence showing that sex-reassignment surgery is the only medical treatment available to relieve or solve the problem of a true transsexual. Second, the court found that "a state plan absolutely excluding the only available treatment known at this stage of the art for a particular condition must be considered an arbitrary denial of benefits based solely on the 'diagnosis, type of illness, or . . . condition.'" Third, the court concluded that Iowa's policy was inconsistent with the objectives of the Medicaid statute because it established an irrebuttable presumption that sex-reassignment surgery was not medically necessary without any formal rulemaking proceedings or hearings. The court also stated that the Medicaid statute required "medical judgments to play a primary role in the determin-
nation of medical necessity," and particularly the judgments of the applicant's treating physician. Finally, the court's finding that transsexual surgery falls within the medical assistance categories of "inpatient hospital services" and "physicians' services furnished by a physician," enabled it to conclude that the surgery must be covered under the state's Medicaid plan unless not medically necessary.

While the court in Pinneke properly objected to the Iowa Department of Social Services' failure to conduct formal rulemaking proceedings or hearings on the medical necessity issue, it erred in deciding to make its own rule that sex-reassignment surgery is medically necessary. The court should have dismissed the action, instructing the parties to seek a PSRO determination and then, if dissatisfied, to follow the review procedure mandated by the federal regulations. In addition, the court ignored the statutory language defining and limiting the role of the attending physician, and instead quoted from the legislative history of the 1965 Social Security Amendments to support its conclusion that the applicant's attending physician should have controlling authority in medical necessity determinations. The provision quoted by the court, however, had been completely superseded by the PSRO legislation. Even in 1965 when the amendments were under consideration the quoted portion of the legislative history was to be considered only in view of the function of utilization review committees whose decisions were to supersede the medical necessity evaluations of attending physicians in disputed cases. Finally, the court incorrectly concluded that sex-reassignment surgery is

171. Id.
172. Id. To support its conclusion, the court quoted a portion of the legislative history of title XIX:

The committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished.

173. See note 27 supra and accompanying text.
174. 623 F.2d at 549.
175. See notes 65-70 supra and accompanying text.
176. See notes 46 & 64 supra and accompanying text.
177. See note 172 supra and accompanying text.
the only available treatment for transsexualism. Not only are other forms of treatment available, but they have been found to be more effective than the surgical procedure.\textsuperscript{179}

In two California cases decided after Rush, but before Pinneke, G.B. v. Lackner\textsuperscript{180} and J.D. v. Lackner,\textsuperscript{181} the plaintiff transsexuals appealed from the Director of the California Department of Health's determination that Medi-Cal does not cover transsexual surgery. In a written opinion, the Director had stated that the surgery was solely for cosmetic purposes and had overruled a Department of Health referee's order that the surgery should be funded.\textsuperscript{182} A Medi-Cal bulletin also stated that funding for transsexual surgery was unavailable.\textsuperscript{183} After hearing testimony from plaintiffs' physicians that the surgery was necessary, and further testimony from a doctor representing the Gender Identity Clinic at Johns Hopkins University to the effect that psychotherapy "has not so far solved the problem," the court held that the surgery was not cosmetic.\textsuperscript{184}

It is unclear from the Lackner decisions precisely who had written the Medi-Cal bulletin denying funding for sex-reassignment surgery. Assuming that the decision was made by an appropriate PSRO, the claimants were entitled to review of that decision by a Statewide Council, by the Secretary of H.H.S., and, finally, by the courts. Apparently that procedure was not followed since state officials of the Medi-Cal program were hearing the appeals. Therefore, the procedure failed to conform to federal regulations prescribing review of medical necessity decisions. The decision is flawed because a court should only be called upon to formulate definitions of medical necessity after appropriate administrative hearings considering PSRO judgments.

In Denise R. v. Lavine,\textsuperscript{185} the petitioner transsexual was denied funding for his sex-reassignment surgery by the New York City Department of Social Services.\textsuperscript{186} After a hearing at which the State Commissioner of Social Services affirmed the denial,\textsuperscript{187}

\textsuperscript{179} See notes 121-31 supra and accompanying text.
\textsuperscript{180} 80 Cal. App. 3d 64, 145 Cal. Rptr. 555 (1978).
\textsuperscript{181} 80 Cal. App. 3d 90, 145 Cal. Rptr. 570 (1978).
\textsuperscript{182} 80 Cal. App. 3d at 66, 145 Cal. Rptr. at 556; 80 Cal. App. 3d at 94, 145 Cal. Rptr. at 572.
\textsuperscript{183} Id. at 66-67, 145 Cal. Rptr. at 556; 80 Cal. App. 3d at 94, 145 Cal. Rptr. at 572.
\textsuperscript{184} Id. at 71, 145 Cal. Rptr. at 559; 80 Cal. App. 3d at 95, 145 Cal. Rptr. at 572.
\textsuperscript{186} Id. at 282, 347 N.E.2d at 895, 383 N.Y.S.2d at 570.
\textsuperscript{187} Id., 347 N.E.2d at 895, 383 N.Y.S.2d at 570.
court action was instituted for review of the Commissioner's decision. The Special Term denied the funding, the Appellate Division reversed,\textsuperscript{188} and the New York Court of Appeals reinstated the Commissioner's ruling denying funding.\textsuperscript{189} The court reasoned that the determination was beyond judicial competence and concluded that "where an administrator adopts one of several conflicting opinions, it is not the province of the Court to substitute its judgment unless the agency's determination is unreasonable or without a basis in law."\textsuperscript{190} The precedential value of this case is, however, limited. When petitioner first requested funding in 1972, the PSRO statute had not been enacted. Thus, whether the procedures conformed to 1972 statutory guidelines is of no consequence today.

In \textit{Doe v. Department of Public Welfare},\textsuperscript{191} the Supreme Court of Minnesota ordered the Department of Public Welfare to provide Medicaid funding for the plaintiff's sex-reassignment surgery. The court began its analysis by looking to the regulations implementing title XIX. By focusing on the proscription against the limitation of funding solely because of the diagnosis, type of illness, or condition, the court held that the state's categorical denial of transsexual surgery was void.\textsuperscript{192} Furthermore, because the state could offer no rationale as to why transsexual surgery was the only type of surgical treatment which, if recommended by a physician, was not covered by the program,\textsuperscript{193} the exclusion was held to be arbitrary.\textsuperscript{194} The court also invalidated the state welfare department's definition of medical necessity which included the requirement that the surgery must eliminate the patient's disability and render him financially self-supporting.\textsuperscript{195} Finally, the court ordered all future cases of this type to be reviewed for medical necessity on a case-by-case basis by a "thorough, complete, and unbiased medical evaluation" conducted by the appropriate state agency.\textsuperscript{196}

The Doe court properly applied parts of the statute. The state agency's initial denial of funding for the surgery clearly violated

\begin{thebibliography}{99}
\bibitem{188} Id., 347 N.E.2d at 895, 383 N.Y.S.2d at 570.
\bibitem{189} Id. at 283, 347 N.E.2d at 895, 383 N.Y.S.2d at 570.
\bibitem{190} Id., 347 N.E.2d at 895, 383 N.Y.S.2d at 570 (citations omitted).
\bibitem{191} 257 N.W.2d 816 (Minn. 1977).
\bibitem{192} Id. at 820.
\bibitem{193} Id.
\bibitem{194} Id. at 821.
\bibitem{195} Id. at 820-21.
\bibitem{196} Id. at 820.
\end{thebibliography}
the regulations, which permit state limitation on scope of coverage only on the basis of medical necessity or fiscal concerns. In addition, the medical necessity definition which was invalidated by the court violated statutory guidelines on norms of care. Certainly, the act of receiving welfare is not a valid measure of medical infirmity; in fact, receiving public assistance is a criterion of eligibility for Medicaid. Finally, the court in *Doe* expressed a willingness to defer to another decisionmaker on the question of medical necessity. Although the court did not name the PSRO as that decisionmaker, review of that type was at least envisioned.

IV. Conclusion

Recent scientific investigation has called into question the medical necessity of sex-reassignment surgery. PSRO determinations and the resulting scope of coverage decisions should necessarily reflect this new awareness. For this to occur, however, state Medicaid agencies and courts must follow the statutory guidelines governing the formulation and review of medical necessity decisions.

Thus far, the courts have not relied upon the PSROs’ ability to respond to the medical community’s changing opinion on the necessity of sex-reassignment surgery. Rather, courts have attempted to formulate a definition themselves for medical necessity in this context. This usurpation of PSRO power is unfortunate because the PSRO system allows courts to effectuate their often expressed desire to leave medical decisions to doctors. On the other hand, the PSRO system cannot be effective unless the states comply with the relevant regulations. State plans which do not provide for PSROs should be rejected and federal funding should be cut off. Otherwise, unnecessary litigation in federal courts will follow and the credibility of the Medicaid program will be severely undermined.

Finally, by concluding that sex-reassignment surgery is medically necessary, courts have contributed to an overemphasis in the medical community on this surgical procedure and a concurrent underemphasis on psychotherapy. Consequently, the transsexual community is being served poorly. Transsexuals are often chan-

197. See 42 C.F.R. § 440.230(b) (1979) (cited by the court as 45 C.F.R. § 249.10 (1976)).
198. See notes 22-23 supra and accompanying text.
neled into a surgical procedure of arguably limited value. Moreover, the relatively low demand for psychotherapy may explain the correspondingly low number of psychotherapists competent to administer the treatment. Perhaps if the Medicaid program were to recognize the limitations of sex-reassignment surgery, more psychotherapists would be willing to provide this alternative treatment, and more transsexuals would be able to benefit from it.

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