INSURANCE CODING ALTERNATIVES FOR TRANS HEALTHCARE

This fact sheet provides information about ICD-10 insurance codes and corresponding diagnoses and treatments the codes are related to. This document is intended to assist trans people in advocating for themselves with their healthcare providers and insurance companies. This information can help guide providers about insurance codes for trans healthcare that are commonly accepted and rejected.

If coverage is denied you can appeal that decision to your insurance company. Once you appeal a denial three times the appeal goes to an outside agency, and is often accepted. Ask your insurance provider about your specific appeals process.

This fact sheet does not guarantee coverage from insurance providers. The best way to get information about your specific plan coverage is to speak with your insurance company.

CODES THAT ARE COMMONLY REJECTED BY INSURANCE PROVIDERS

CODE	CONDITION	COMMENTS
F64	Gender Dysphoria/Gender Identity Disorder	Rarely covered in North Carolina but employers can request expansion.
Q56.3	Intersex code requires chromosomal documentation	Typically diagnosed in childhood and allow for full spectrum of gender surgery

**A note about F64: Some insurance providers will require this code for gender affirming surgeries. It is also often required for adolescents to get hormone interventions covered.*

CODES THAT ARE COMMONLY ACCEPTED BY INSURANCE PROVIDERS

CODE	CONDITION	COMMENTS
E34.9	Endocrine disorder, unspecified	Hormone replacement therapy
Z79.899	Other long term (current) drug therapy	Labs related to hormone therapy including potassium, kidney and liver function, and blood counts
N62	Breast hypertrophy	Breast reduction/mastectomy
N64.4	Mastodynia	Mastectomy
N65	Deformity of reconst. Br	Mastectomy or reconstruction
N94.1	Dyspareunia (pain with sex)	Hysterectomy
N92.6	Irregular menses	Hysterectomy/IUD
N94.6	Painful menses	Hysterectomy/Hormonal therapies/IUD
N83.2	Ovarian cyst	Removal of ovaries
R10.2	Pelvic pain	Hysterectomy/removal of ovaries
N90.89	Hypertrophy of the clitoris	Clitoroplasty
N90.69	Labial hypertrophy	Labiaplasty
N94.819.2	Vulvar pain	Vulvoplasty
N50.819	Orchialgia	Orchiectomy

Campaign for Southern Equality has created this fact sheet to assist trans and gender diverse people seeking medical interventions in advocating for ourselves with our healthcare providers and insurance companies. Questions about coverage and specific plans should always be directed to insurance providers.

HERE'S SOME ADDITIONAL INFORMATION THAT MAY BE HELPFUL AS YOU GO THROUGH THE APPEALS PROCESS:

This information is pulled directly from "Gender Reassignment Surgery Model National Coverage Determination," a toolkit created by the Transgender Medicine Model National Coverage Determination Working Group with the assistance of Nick Gorton, MD of Lyon-Martin in San Francisco:

Most insurers have an exclusion of coverage for transition-related coverage as their standard language and do not remove it unless a state has issued guidance that says that exclusions of trans care are illegal, or the plan receives federal funds to pay for premiums (or payment for a third party administer), such as a federal or state marketplace plan, Medicare or Medicaid programs (many states are out-of-compliance with the federal rules for their Medicaid programs). This is the most common, and most folks don't know they have an exclusion until they are told where to look. This does not mean that it is impossible to get care covered, but the appeals process is much harder.

Coverage for specific procedures: Some coverage is categorically excluded because they are viewed as cosmetic (i.e. breast augmentation, body contouring, facial feminization procedures) - generally speaking, these are hard to appeal and clearly delineate why they are medically necessary to meet the insurer's standards. Some "subprocedures" are also not covered, even if they main procedure is covered (i.e. double mastectomy is covered for transgender men, but not nipple reconstruction; phalloplasty may be covered, but the testicular implants are not, often citing cosmetic purposes) - when this occurs, the service is easier to appeal, because most of these procedures are available to cisgender people, and the case can be made that the "cosmetic ruling" is being applied to trans people for the sake of denying care (i.e. sex discrimination).

Coverage issues can occur when someone is getting a "sex-specific procedure" such as a pap smear or a PSA testing for prostate exams, this is typically related to what gender marker the patient currently has on their health insurance account. While this discrimination is illegal, this happens with some frequency, but can be fixed using KX or 45 modifier. This is more of an educational issue to medical providers, but most do not know that they can code in this fashion to assure that their patient's care gets covered."

CAMPAIGN FOR SOUTHERN EQUALITY

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Sources: https://www.cms.gov/medicare/coverage/determinationProcess/downloads/Kalra_comment_01022016.pdf • https://transline.zendesk.com/hc/en-us/articles/229372908-Coding-for-Transition-Related-Care