Insurance Coverage and Coding Considerations in Gender Affirming Primary Care

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1

Outline

- Health disparities specific to the primary care context
- General primary care and coding
- Hormone therapy & reproductive health considerations and coding
- Common pitfalls and challenges
- Costing considerations

- Additional context of state and local regulations, requirements, and exclusions

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Table 2.

Ann Fam Med. 2020 Nov; 18(6): 528–534.

Association Between Insurance Status and Gender-Affirming Hormone Use Among Respondents the 2015 US Transgender Survey

Characteristic	Use of Nonprescription Hormones, Among Those Using Hormones[a] (n = 12,037)		Use of Hormones, Among Those Interested (n = 21,237)	
	aOR (95% CI)	*P* Value	aOR (95% CI)	*P* Value
Uninsured (compared with insured)	2.64 (1.88-3.71)	<.001	0.37 (0.24-0.56)	<.001

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Table 3.

Ann Fam Med. 2020 Nov; 18(6): 528–534.

Association Between Insurance Claim Denial and Gender-Affirming Hormone Use Among Insure Respondents to the 2015 US Transgender Survey

Characteristic	Use of Nonprescription Hormones, Among Those Using Hormones[a] (n = 10,841)		Use of Hormones, Among Those Interested (n = 18,516)	
	aOR (95% CI)	*P* Value	aOR (95% CI)	*P* Value
Claim for hormones denied by insurance	2.53 (1.61-3.97)	<.001	0.89 (0.57-1.39)	.60

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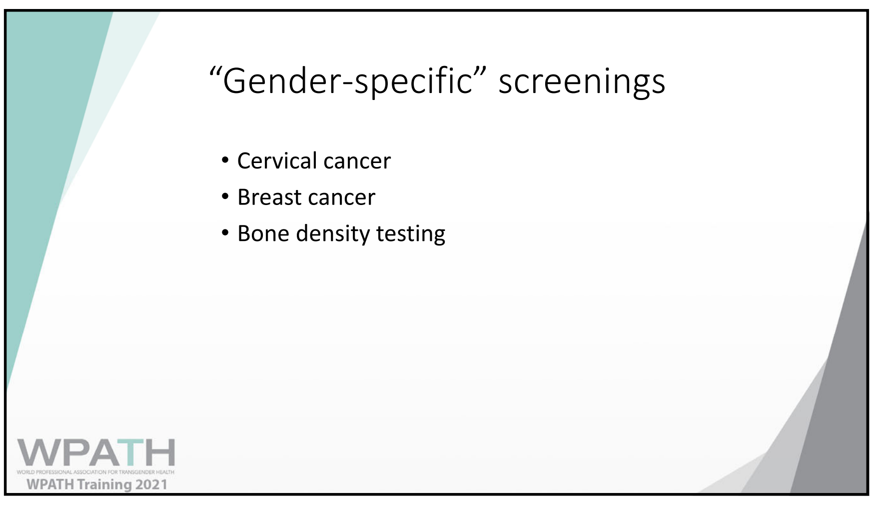

5

Can Fam Physician. 2019 Jan; 65(1): e30–e37.

Table 4.

Unadjusted and adjusted ORs comparing likelihood of trans individuals being screened for cancer compared with cis individuals

TYPE OF CANCER SCREENING	UNADJUSTED OR (95% CI)	ADJUSTED OR* (95% CI)
Cervical	0.46 (0.30 to 0.72)	0.39 (0.25 to 0.62)
Breast	0.28 (0.13 to 0.60)	0.27 (0.12 to 0.59)
Colorectal	0.51 (0.27 to 0.99)	0.50 (0.26 to 0.99)

OR—odds ratio.

*Adjusted for age, neighbourhood income quintile, and number of visits.

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	Transgender female	Transgender male without top surgery	Transgender male who has undergone top surgery
University of California San Francisco29	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography every 2 years	Screening similar to that for cisgender women	Dialog with patients about risks
Fenway Health30	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography annually	Screening similar to that for cisgender women	Consider yearly chest examinations
University Hospitals Cleveland Medical Center31	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography every 2 years	Screening similar to that for cisgender women	–
Susan G. Komen Puget Sound32	Age ≥50 years AND at least 5 years of hormone therapy: screening mammography annually	Annual screening mammography beginning at age 50 years	Annual chest and axillary examinations If breast tissue remaining, annual screening mammography beginning at age 50 years
Canadian Cancer Society33	Age 50–69 years AND at least 5 years of hormone therapy: screening mammography every 2 years	Screening mammography every 2 years between age 50 and 69 years	Screening mammography every 2 years between age 50 and 69 years
Endocrine Society Clinical Practice Guidelines34	Screening similar to that for cisgender women, no prescribed length of hormone exposure	Screening similar to that for cisgender women	–

Breast Oncology | Published: 07 June 2021

Breast Cancer Risk and Screening in Transgender Persons: A Call for Inclusive Care

Callisia N. Clarke MD, MS, FACS, FSSO, Chandler S. Cortina MD, Oluwadamilola M. Fayanju MD, MA, MPHS, Lesly A. Dossett MD, MPH, Fabian M. Johnston MD, MHS & Sandra L. Wong MD, MS

Annals of Surgical Oncology (2021) | Cite this article

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Cervical screening pitfalls

- Denial of coverage
- Inability to enter order
- Mismatch
- Changed to anal screening order

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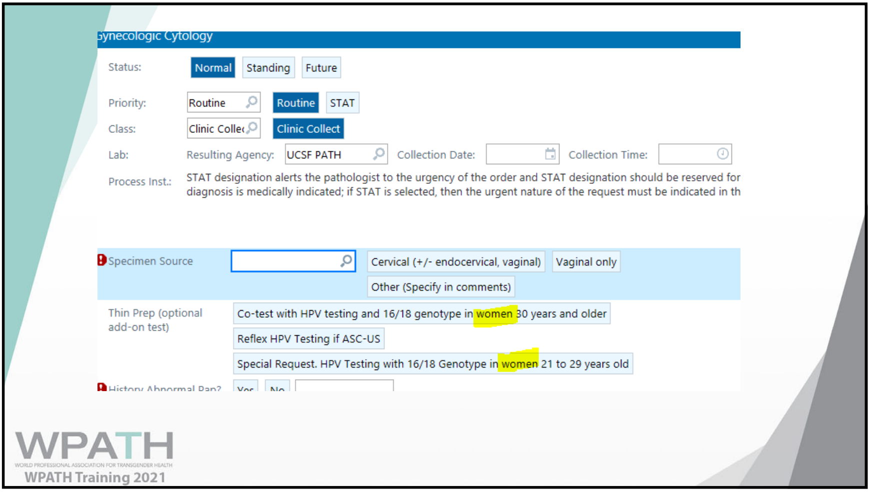

"Gender-specific diagnostics and treatment"

- Testicular
- Penile
- Vaginal
- Vulvar
- Uterine
- Ovarian
- Breast
- Cervical

"Gender-specific" diagnostics and treatment

- Will conflicts, no-match, or denials arise when facing these scenarios?

575960	Gender dysphoria	F64.9
593625	Gender dysphoria in adolescent and adult	F64.0
1547864	Gender dysphoria in adult	F64.0
593626	Gender dysphoria in pediatric patient	F64.2
196359	Gender identity disorder	F64.9
441303	Gender identity disorder in adolescence and adulthood	F64.0
302.85.ICD-9	Gender identity disorder in adolescents or adults	F64.0
425524	Gender identity disorder in adult	F64.0
302.6.ICD-9-	Gender identity disorder in children	F64.2
1547460	Gender identity disorder in pediatric patient	F64.2
176246	Gender identity disorder of adolescence	F64.0
176247	Gender identity disorder of adolescence, previously asexual	F64.0
176249	Gender identity disorder of adolescence, previously heterosexual	F64.0

453054	Family history of gender identity disorder	Z81.8
514848	H/O gender identity disorder	Z86.59
1735909	History of gender dysphoria in childhood	Z86.59
452195	History of gender identity disorder	Z86.59
514849	Hx of gender identity disorder	Z86.59
1482472	Other gender identity disorders	F64.8
325110	Person who has undergone gender reassignment surgery	Z87.890
296186	Sexual and gender identity disorders	F64.2
1750529	Sexual relationship problem due to gender identity confusion	F66
325109	Status post gender reassignment surgery	Z87.890
325144	Trans-sexualism, status post gender reassignment surgery	Z87.890

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Other encounter diagnostic codes

1312060	Hypogonadism in male	E29.1
260254	Hypogonadism male	E29.1
260255	Hypogonadism with anosmia (CMS code)	E23.0
213426	Hypogonadism, hypogonadotropic, with anosmia (CMS code)	E23.0
260256	Hypogonadism, male	E29.1
1609202	Hypogonadism, mitral valve prolapse, and intellectual disability syndrome	Q87.89, E29.1, I34.1,
289700	Hypogonadism, ovarian	E28.39
260257	Hypogonadism, testicular	E29.1

178667	Endocrine disorder related to puberty	E34.8
1431555	Endocrine disorder, unspecified	E34.9

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Reproductive health and fertility considerations

- Pre-treatment preservation (sperm, oocyte, embryo, gonadal tissue)
- Post-treatment gamete production and conception
- Contraception prescribing
- Contraception procedures (implant, IUD)
- Sterilization procedures NOT relating to gender affirmation
  - Vasectomy/Tubal ligation

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516879	Infertility due to luteal phase defect	N97.8
174465	Infertility due to obstruction of efferent ducts	N46.8
517804	Infertility due to oligo-ovulation	N97.0
174456	Infertility due to oligospermia	N46.11
223170	Infertility due to spermatogenic arrest (complete)	N46.01
244434	Infertility male	N46.9
248835	Infertility management	Z31.9
454786	Infertility of tubal origin	N97.1
223290	Infertility with anomaly of cervical mucus	N88.3
223292	Infertility with dysmucorrhea	N88.3
439846	Infertility, anovulation	N97.0
226954	Infertility, female	N97.9
378649	Infertility, female, due to immunological factor	N97.8
260681	Infertility, female, origin, cervical	N88.3
260682	Infertility, female, origin, vaginal	N97.8

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Medical vs. pharmacy plan conflicts

- Injected medications (testosterone, estradiol, leuprolide) may be listed covered under medical plan
- Requirement for in-office injections may be prohibitive
- Lack of pre-approval or pre-authorization may put patient at risk of uncovered costs not discovered until after treatment received

Cracking the Code to Better Health

Medical 'Z-codes' tied to social issues like homelessness and unemployment offer data that can help improve patients' lives and, in turn, their health. Why aren't more physicians using them?

By Sarah True | Jan. 13, 2021, at 6:30 a.m.

Ultimately, a lack of insurance reimbursement may explain why these Z-codes are so little used. Insurance companies pay for services based on diagnosis and procedure codes contained in medical documentation and submitted in claims, but Z-codes for social determinants of health don't trigger such payments, and this means "there's not a reason for providers to use them," Donovan says.

CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes

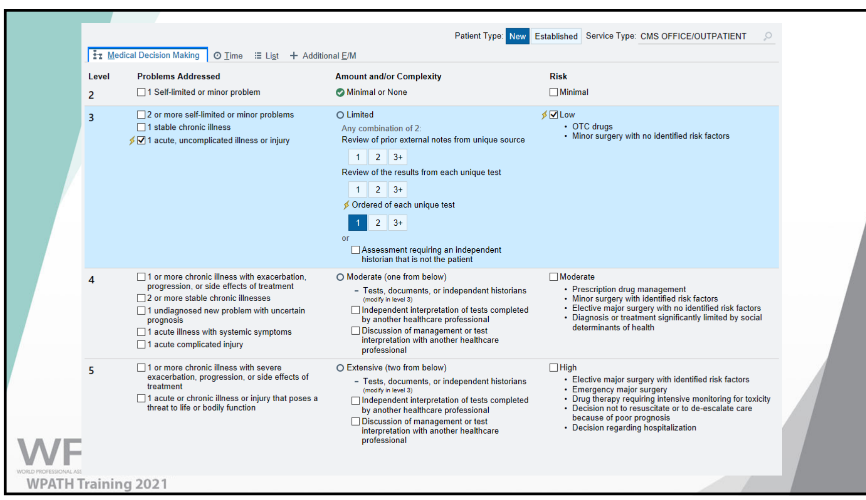
This document includes the following CPT E/M changes, effective January 1, 2021:

- **E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215**
- **Revised Office or Other Outpatient E/M codes 99202-99215**

In addition, this document has been updated to reflect technical corrections to the E/M Guidelines: were posted on March 9, 2021 and effective January 1, 2021:

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management

99204 99214	**Moderate**	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health



21

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) for other office or other outpatient services are:

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, noninsulin- dependent diabetes, cataract, or benign prostatic hyperplasia.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

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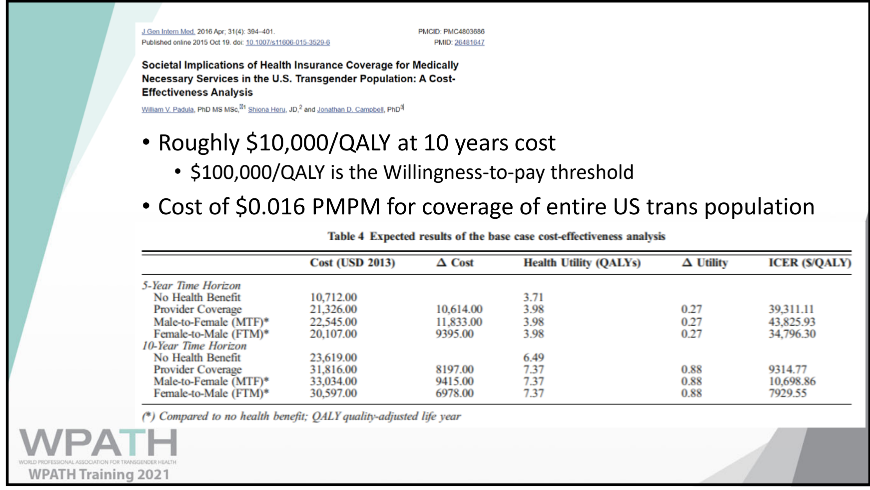

J Gen Intern Med. 2016 Apr; 31(4): 394–401. PMCID: PMC4803686
Published online 2015 Oct 19. doi: 10.1007/s11606-015-3529-6 PMID: 26481647

Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis

William V. Padula, PhD MS MSc,[1] Shiona Heru, JD,[2] and Jonathan D. Campbell, PhD[3]

- Roughly $10,000/QALY at 10 years cost
  - $100,000/QALY is the Willingness-to-pay threshold
- Cost of $0.016 PMPM for coverage of entire US trans population

Table 4 Expected results of the base case cost-effectiveness analysis

	Cost (USD 2013)	Δ Cost	Health Utility (QALYs)	Δ Utility	ICER ($/QALY)
5-Year Time Horizon					
No Health Benefit	10,712.00		3.71		
Provider Coverage	21,326.00	10,614.00	3.98	0.27	39,311.11
Male-to-Female (MTF)*	22,545.00	11,833.00	3.98	0.27	43,825.93
Female-to-Male (FTM)*	20,107.00	9395.00	3.98	0.27	34,796.30
10-Year Time Horizon					
No Health Benefit	23,619.00		6.49		
Provider Coverage	31,816.00	8197.00	7.37	0.88	9314.77
Male-to-Female (MTF)*	33,034.00	9415.00	7.37	0.88	10,698.86
Female-to-Male (FTM)*	30,597.00	6978.00	7.37	0.88	7929.55

(*) Compared to no health benefit; QALY quality-adjusted life year

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23