National Center for TRANSGENDER EQUALITY

MEDICARE AND TRANSGENDER PEOPLE

Updated May 2014

Medicare is one of America's most important health programs, providing health insurance for millions of older adults and people with disabilities. As with private insurance, transgender people sometimes encounter confusion about what is covered or barriers to accessing coverage—both for transition-related care and for routine preventive care. This document provides an overview of benefit questions that may arise for transgender people and information on what to do in response to an initial denial of coverage.

WHAT DOES MEDICARE COVER FOR TRANSGENDER PEOPLE?

Medicare covers routine preventive care regardless of gender markers.

Medicare covers routine preventive care for all eligible persons, including mammograms, pelvic and prostate exams. Medicare and many private plans may initially refuse coverage of services that seem to not match the gender of the person in Social Security records. Medicare and insurers often have a computer-matching program that only allows services to be paid for if the gender "marker matches," as a means of preventing mistakes and fraud in billing.This has the unintended consequence of denying claims for procedures that many transgender people need. However, Medicare beneficiaries have a right to access services that are appropriate to their individual medical needs and necessary care should be provided regardless of the gender marker in one's Social Security or other records. Later in this document we discuss what to do when coverage is wrongly denied due to an apparent gender mis-match.

Medicare covers medically necessary hormone therapy.

Medicare also covers medically necessary hormone therapy for transgender people. These medications are part of Medicare Part D prescription drug plan formularies (lists of covered medications) and should be covered when prescribed. Sometimes coverage may be initially wrongly refused due to an apparent inconsistency of the hormones with a gender marker in a person's records. Nevertheless, Medicare beneficiaries have a right to access prescription drugs that are appropriate to their medical needs.

Medicare covers medically necessary sex reassignment surgery.

For many years, Medicare did not cover sex reassignment surgery for transgender people due to a decades-old policy that categorized such treatment as "experimental." That exclusion was eliminated in May 2014, and there is now no national exclusion for transition-related health care under Medicare. This means that coverage decisions for transition-related surgeries will be made individually on the basis of medical need and applicable standards of care, similar to other doctor or hospital services under Medicare.

WHAT HAPPENED TO THE MEDICARE TRANSGENDER EXCLUSION?

In 1989, Medicare adopted a National Coverage Determination categorically excluding what it called "Transsexual Surgery" from Medicare coverage, regardless of a person's individual medical conditions and needs. In May 2014, the U.S. Department of Health and Human Services (HHS) Departmental Appeals Board decided an appeal from a Medicare beneficiary and decided that the 1989 exclusion was based on outdated, incomplete, and biased science, and did not reflect contemporary medical science or standards of care. Accordingly, the Medicare policy of categorically excluding coverage of transition-related surgery, regardless of medical need, was invalidated. This means coverage decisions for transition-related care will now be made on an individual basis like all other services under Medicare.

HOW DO I OBTAIN COVERAGE FOR A MEDICALLY NECESSARY, TRANSITION-RELATED PROCEDURE?

Transition-related procedures should be handled like all other services under Medicare. You need to be approved for any procedure by your medical provider(s), your provider(s) must accept Medicare coverage, and you must meet any applicable deductible. If you have a Medicare Advantage (managed care) plan, your provider may need to seek prior authorization for coverage of a procedure. Check with the provider or your plan.

If you have traditional (fee for service) Medicare, medical procedures can normally be performed anywhere in the United States. If you have a Medicare Advantage (managed care) plan, you may need prior approval to see an out-of-network provider. Travel expenses are typically not covered.

At present, some providers of transition-related procedures may not accept Medicare coverage. Because this care has always been excluded from Medicare in the past, it may be difficult and confusing at first to find an appropriate provider who can confirm they will accept Medicare coverage. We hope and expect that, over time, the number of qualified providers accepting Medicare will grow.

WHAT DO I DO WHEN COVERAGE IS DENIED?

Original Medicare

To address inappropriate denials of coverage for preventive care and other services that are typically thought of as gender-specific, the Center for Medicare and Medicaid Services (CMS) has approved a special billing code (condition code 45) to assist processing of claims under original Medicare (Parts A and B). This billing code should be used by your physician or hospital when submitting billing claims for services where gender mis-matches may be a problem. When used with standard billing codes doctors use for specific procedures, this code alerts Medicare's computer system to ignore an apparent gender mis-match and allow your claim to be processed. Details are explained in the Chapter 32 of the Medicare Claims Processing Manual (see the Resources section below).

If you experience a denial of coverage you belief to be inappropriate (including coverage of preventive services that cannot be resolved as described above, or coverage of transition-related care), you may file an appeal, as described below.

Private Medicare (Medicare Advantage, Medicare Cost Plus or Medicare Part D, etc.)

These plans should also cover routine preventive care and transition-related care for transgender people, however, the Medicare override "condition code 45" cannot be used for private Medicare Advantage plans.
If you have a Medicare Advantage, Medicare Cost Plus or Medicare Part D plan and you are informed that your plan will not cover a service that is medically appropriate for you (for example, when a pharmacist tells you your plan will not cover your prescription hormones), the first thing you need to do is request a written "coverage determination" from the plan. This request must be submitted with a doctor's statement explaining the medical necessity of the item or service to be covered. Submit any documentation you can provide from your doctor supporting the medical necessity of the item or service. For prescription drugs, it's best to use Medicare's "Model Coverage Determination Request" form (see the Resources section below).

Appealing a negative coverage determination:

If you have original Medicare and a claim has been denied (for example, when Medicare refuses to cover your doctor visits or doctor-recommended surgery), you have the option of appealing that determination within 120 days, pursuant to the standard appeal procedures for all Medicare claims. The first level of appeal is called a "redetermination." You, or your doctor, or any other person whom you appoint (such as a family member or friend) can call or write to the company that handles your Medicare claims, as indicated on your most recent Medicare Summary Notice, and ask them to cover your claim. your Medicare claims, as indicated on your most recent Medicare Summary Notice, and ask them to cover your claim. If another person is going to assist you in this process, you should contact the company to

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Once the company receives your appeal, they usually take one week to inform you of their decision (though faster appeals are possible in some circumstances). If their answer, called a "redetermination," is unfavorable, there are several additional levels of possible review by Medicare and ultimately by a court. Review Medicare's page "How do I file an appeal?" for more details (see the Resources section below).

If a private Medicare plan denies coverage, the appeals process is similar to original Medicare, but you must start by submitting an appeal to the plan. You, your doctor or your representative will typically need to file an appeal within 60 days with your plan, usually in writing (though some plans will allow appeals to be made by phone). Specific appeal procedures vary by plan, and are specified in each plan's materials. For more information, see the Medicare page "How do I file an appeal?" and the resource "Medicare Prescription Drugs Coverage: How to Request a Coverage Determination, File an Appeal, or File a Complaint" (see the Resources section below).

HOW DO I CHANGE THE GENDER MARKER ON MY MEDICARE CARD?

Original Medicare (Parts A and B) beneficiary cards list gender on the front of the card. This gender marker is to the gender in your Social Security Administration (SSA) record. If you change the gender in your SSA record, you may request a replacement card reflecting the change. For more information on changing your SSA record, see NCTE's resource **Transgender People and the Social Security Administration**. NCTE continues to advocate that the gender marker be removed from Medicare cards entirely.

WHAT IF I AM TREATED WITH DISRESPECT?

If you encounter disrespect, discrimination, harassment or other inappropriate treatment related to your gender identity or transgender status, you may make a complaint with the appropriate entity. For problems when making inquiries or appeals in a private Medicare plan, you may file a complaint or grievance with your plan. For any other customer service problems, we recommend contacting your regional Center for Medicare and Medicaid Services (CMS) office. We encourage you to also share your experience with NCTE to aid in our advocacy efforts.

Other Resources

For general Medicare information
1-800-MEDICARE (633-4227)

Medicare Claims Processing Manual, Chapter 32 - Addressing Gender Discrepancies
http://www.cms.gov/manuals/downloads/clm104c32.pdf (see section 240)

Medicare Interactive - A Resource from the Medicare Rights Center
http://www.medicareinteractive.org

Medicare & You 2014 Handbook
http://www.medicare.gov/publications/pubs/pdf/10050.pdf

Information About Filing Appeals and Complaints

How Do I File an Appeal?
http://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html

Medicare Prescription Drug Coverage: How to Request a Coverage Determination, File an Appeal, or File a Complaint
http://www.cms.gov/partnerships/downloads/11112.pdf

Forms and other information for prescription drug appeals
https://www.cms.gov/MedPrescriptDrugApplGriev/

Contact Information for Regional CMS (Medicare) Offices
http://www.cms.gov/RegionalOffices/

Transgender People and the Social Security Administration
http://transequality.org/Resources/SSAResource_June2013.pdf