Insurance Coverage and Coding Considerations in Gender Affirming Primary Care

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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

Table 2. Association Between Insurance Status and Gender-Affirming Hormone Use Among Respondents to the 2015 US Transgender Survey

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Use of Nonprescription Hormones, Among Those Using Hormones (n = 12,037)</th>
<th>Use of Hormones, Among Those Interested (n = 21,237)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>aOR (95% CI)</td>
<td>P Value</td>
</tr>
<tr>
<td>Uninsured (compared with insured)</td>
<td>2.64 (1.88-3.71)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Table 3. Association Between Insurance Claim Denial and Gender-Affirming Hormone Use Among Insured Respondents to the 2015 US Transgender Survey

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Use of Nonprescription Hormones, Among Those Using Hormones (n = 10,841)</th>
<th>Use of Hormones, Among Those Interested (n = 18,516)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>aOR (95% CI)</td>
<td>P Value</td>
</tr>
<tr>
<td>Claim for hormones denied by insurance</td>
<td>2.55 (1.61-3.97)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
“Gender-specific” screenings

- Cervical cancer
- Breast cancer
- Bone density testing

Cervical screening pitfalls

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

<table>
<thead>
<tr>
<th>TYPE OF CANCER SCREENING</th>
<th>UNADJUSTED OR (95% CI)</th>
<th>ADJUSTED OR* (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical</td>
<td>0.46 (0.30 to 0.72)</td>
<td>0.39 (0.25 to 0.62)</td>
</tr>
<tr>
<td>Breast</td>
<td>0.28 (0.13 to 0.60)</td>
<td>0.27 (0.12 to 0.59)</td>
</tr>
<tr>
<td>Colorectal</td>
<td>0.31 (0.27 to 0.99)</td>
<td>0.30 (0.26 to 0.99)</td>
</tr>
</tbody>
</table>

OR—odds ratio.

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

Other encounter diagnostic codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>170900</td>
<td>Hypogamadon in male</td>
</tr>
<tr>
<td>200204</td>
<td>Hypogamadon male</td>
</tr>
<tr>
<td>240256</td>
<td>Hypogamadon with anoxia (ICD-10) code</td>
</tr>
<tr>
<td>215426</td>
<td>Hypogamadon, hyponoadotic, with anoxia (ICD-10) code</td>
</tr>
<tr>
<td>260256</td>
<td>Hypogamadon, male</td>
</tr>
<tr>
<td>3000002</td>
<td>Hypogamadon, mental, vs. polydysplasia, genitopelvic syndrome</td>
</tr>
<tr>
<td>297700</td>
<td>Hypogamadon, ovary</td>
</tr>
<tr>
<td>200257</td>
<td>Hypogamadon, testis</td>
</tr>
</tbody>
</table>

170667 | Endocrine disorder related to puberty | E34.8 |
1431566 | Endocrine disorder, unspecified | E34.9 |
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 help social workers 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报 | Jun. 13, 2021, 9:00 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.
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

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, it is not stable, even if the pressures are not changing and the patient is asymptomatic.

Examples may include well-controlled hypertension, non-insulin-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.