National Center for TRANSGENDER EQUALITY

MEDICARE BENEFITS AND TRANSGENDER PEOPLE

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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 limitations in their Medicare coverage or confusion about what is covered - 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 automatically refuse coverage of services that appear inconsistent with a gender marker in Social Security records as a means of preventing erroneous or fraudulent billing, with the unintended consequence of denying claims for procedures that many transgender people need. Medicare beneficiaries have a right to access services that are appropriate to their individual medical needs. Later in this document we discuss what to do when coverage is wrongly denied due to an apparent gender discrepancy.

Medicare covers medically necessary hormone therapy.
Medicare also covers medically necessary hormone therapy. 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 to their medical needs.

Medicare does not cover sex reassignment surgery.
Medicare currently does not cover sex reassignment surgery for transgender people. This exclusion is due to a decades-old policy that categorizes such treatment as "experimental." NCTE is working to have this outdated policy re-evaluated on the basis of current science, but this process may take several years. This exclusion applies only to surgical procedures and should not apply to pre-surgical labs, post-surgical follow-up care, or any other medically appropriate treatment for a transgender beneficiary that is generally a covered service.

WHAT DO I DO WHEN COVERAGE IS DENIED?

Original Medicare
To address inappropriate denials of coverage, 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 discrepancies 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 discrepancy 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).

WHAT DO I DO WHEN COVERAGE IS DENIED? (CONTINUED)

Private Medicare (Medicare Advantage, Medicare Cost Plus or Medicare Part D, etc.)
These plans should also cover routine preventive care and hormone therapy 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 drugs including 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), you have the option of appealing that determination within 120 days, persuant 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. If another person is going to assist you in this process, you should contact the company to learn how to appoint this person to be your representative.

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 document "How to File a Medicare Part A or Part B Appeal in Original Medicare" 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 documents "Medicare Advantage Plans and Medicare Cost Plans: How to file a Complaint (Grievance or Appeal)" and "Medicare Prescription Drugs Coverage: How to Request a Coverage Determination, File an Appeal, or File a Complaint" (see the Resources section below).

WHAT IF I HAVE A CUSTOMER SERVICE PROBLEM?

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 2011 Handbook
http://www.medicare.gov/publications/pubs/pdf/10050.pdf

Information About Filing Appeals and Complaints

How to File a Medicare Part A or Part B Appeal in Original Medicare
http://www.medicare.gov/publications/pubs/pdf/11316.pdf

Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal)
http://www.medicare.gov/publications/pubs/pdf/11312.pdf

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

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

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