SUPPORTING YOUR PATIENT IN APPEALING AN INSURANCE DENIAL

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INTRODUCTION

Over the past decade shifts have occurred towards insurance coverage for gender affirming care of transgender, nonbinary, two-spirit, and gender expansive (T/GE) populations[1]. Currently, 51% of the LGBT population in the US reside in states that explicitly cover services related to gender transition in state Medicaid coverage[2].

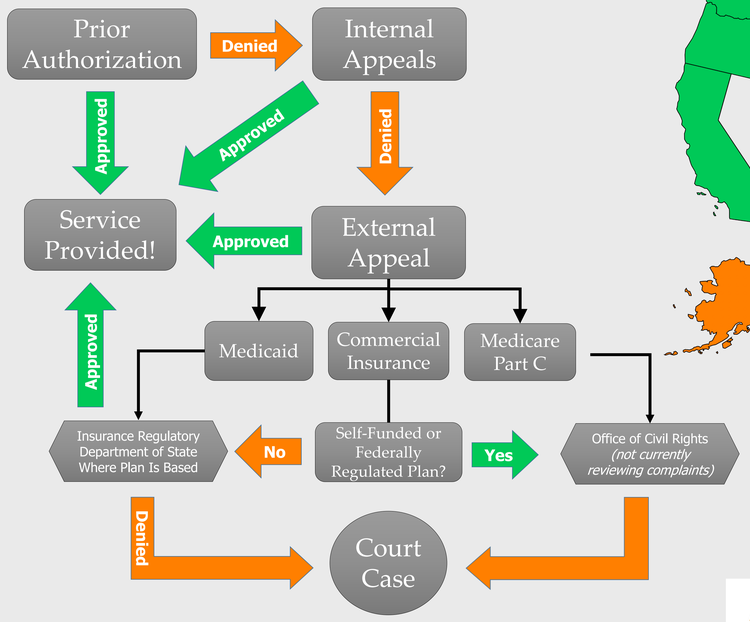
With increasing inclusion of T/GE services in health plan policies, implementation has created substantial documentation burden for primary care providers, mental health clinicians, and surgeons assisting patients in accessing care. Differing interpretations of Standards of Care by insurance companies and the clinicians treating T/GE people, as well as a lack of awareness of state non-discrimination laws, can result in unnecessary (and often unlawful) denials of care for a population with pre-existing health disparities[3].

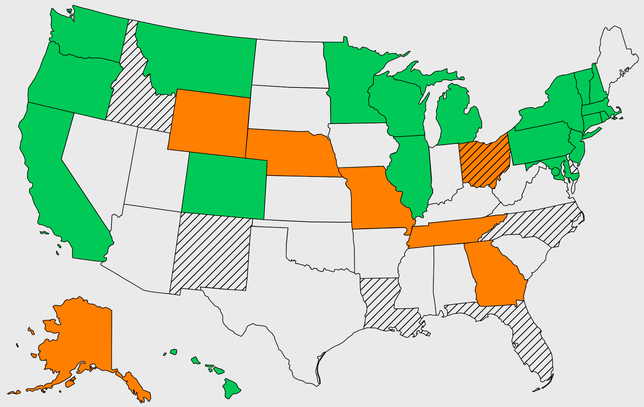
Skill building is needed for the T/GE health professionals in the US to more effectively navigate and advocate for their clients in the appeal process. These skills have been utilized to successfully advocate for coverage of a large spectrum of gender affirming interventions, from packers as durable medical equipment to hairline restoration.

1. Nolan, I. T., Kuhner, C. J., & Dy, G. W. (2019). Demographic and temporal trends in transgender identities and gender confirming surgery. *Translational Andrology and Urology*, 8(3), 184–190. https://doi.org/10.21037/tau.2019.04.09
2. Movement Advancement Project (2019). *Healthcare Laws And Policies*. Retrieved from http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/medicaid
3. Safer, J. D., Coleman, E., Feldman, J., Garofalo, R., Hembree, W., Radix, A., & Sevelius, J. (2016). Barriers to healthcare for transgender individuals. *Current Opinion in Endocrinology & Diabetes and Obesity*, 23(2), 168–171. https://doi.org/10.1097/med.0000000000000227

SPECIFIC AIM

To increase clinical provider skills in writing effective appeal letters for denials received by patients in their care.





Regulation requiring Medicaid coverage of T/GE care

Regulation banning Medicaid coverage of T/GE care

No ban or requirement Medicaid coverage of T/GE care

Surgery coverage through Medicaid occurring despite no requirement or ban

METHODS

We propose a three-step methodology to constructing effective appeal letters:

1. Include patient-specific rationale

Scan for sample initial referral letter with baseline patient-specific details:

2. Cite scientific literature and consensus statements

Scan for compiled T/GE literature and professional society statements:

3. Include legal rationale supporting patient's access to care

Scan for directory of state and nationally applicable legal rationale:

Adolescent Minor Chest Surgery

I am writing regarding your initial determination to deny Mr. Peter Patient's chest reduction procedure. I am Mr. Patient's primary care physician, and he has been in my care since August of 2017. Additionally, I am a board-certified Pediatrician and specialize in the care of transgender adolescents. I have no doubt that in Mr. Patient's case, medical necessity can be demonstrated for this procedure as required by New York Medicaid's regulations regarding Transgender Related Care and Services[1].

Mr. Patient experiences severe gender dysphoria related to the secondary sex characteristics of his natal sex, including his chest. He has had hormone treatment appropriate to his individual goals, including testosterone injections starting 10/1/2017. He has lived for well more than twelve months in a role congruent with his gender identity, living as a transgender man starting in September of 2015. There are no significant mental or physical health conditions that would contraindicate this gender affirming surgery, and he has the capacity to give informed assent to treatment. Two qualified mental health clinicians, Social Worker, LCSW and Psychiatrist, MD have concurred with my assessment in this regard. His legal guardian has also participated fully in his treatment plan, giving her informed consent as well.

The World Professional Association of Transgender Health includes specific guidance in the most recent Standards of Care (SOC) discussing chest masculinization for FtM (female to male transgender) patients before the age of 18. The adolescent section on Irreversible Interventions of the SOC addresses this: "Genital surgery should not be carried out until patients reach the legal age of majority in a given country (…) Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment.[2]" The SOC continues to discuss the negative impact of withholding treatments for adolescents in the section, Risks of Withholding Medical Treatments for Adolescents: "Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization." Medical literature subsequent to the publishing of the most recent standards of care continues to support chest reduction surgery in adolescent minors[3,4], in addition to consensus statements from additional professional organizations[5,6].

Recommendation
As discussed above, Mr. Patient meets all standards set forward in the SOC to be recommended as a candidate for this procedure. Given his diagnosis of persistent gender dysphoria (gender identity disorder ICD-9 302.85, ICD-10 F64.0), I have been collaborating with the mental health providers who have submitted additional recommendations, as well as Dr. Surgeon to whom Mr. Patient was referred, to provide appropriate treatment for the management of his documented symptoms of gender dysphoria. He has responded well to this treatment so far. The persistent gender dysphoria which originates from having developed Tanner 5 breasts negatively affects Mr. Patient's health and well-being, and this is not expected to change with the patient's age or time receiving masculinizing hormone therapy. The only treatment for this is a bilateral reduction mammoplasty with chest reconstruction.

It is my professional opinion that a chest reduction surgery is the next step in his treatment plan, that this will greatly improve his wellbeing, and that this treatment is medically necessary to treat his gender dysphoria. Please contact me if there is further documentation needed to demonstrate medical necessity for Mr. Patient's procedure. We will assist Mr. Patient in accessing this treatment, including by referring him to legal services that will support him in overturning an unlawful denial that contradicts expert medical opinion and regulatory guidance.

Thank you,

Pediatrician, MD

1. 18 N.Y.C.R.R. § 505.2(l)(3) https://docs.dos.ny.gov/info/register/2016/dec7/pdf/rulemaking.pdf
2. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … Zucker, K. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. International Journal of Transgenderism, 13(4), 165–232. https://doi.org/10.1080/15532739.2011.700873
3. Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults. JAMA Pediatrics, 172(5), 431. https://doi.org/10.1001/jamapediatrics.2017.5440
4. Schechter, L. (2018). 3.4 Gender Confirming Surgical Care in Adolescence: Evidence, Timing, Options, and Outcomes. Journal of the American Academy of Child & Adolescent Psychiatry, 57(10), S123–S124. https://doi.org/10.1016/j.jaac.2018.07.568
5. Rafferty, J. (2018). Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics, 142(4), e20182162. https://doi.org/10.1542/peds.2018-2162
6. Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., … T'Sjoen, G. G. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline. The Journal of Clinical Endocrinology & Metabolism, 102(11), 3869–3903. https://doi.org/10.1210/jc.2017-01658

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Facial Gender Confirming Surgery

I am writing regarding your initial determination to deny Ms. Patricia Patient's Facial Gender Confirming Surgery (FGCS). I have no doubt that in Ms. Patient's case, medical necessity can be demonstrated as required by California's Insurance Gender Non-Discrimination Act (AB1586)[1].

Ms. Patient is a transgender woman, diagnosed with Gender Dysphoria of Adulthood (ICD-10 F64.0). She notes she first knew her gender identity differed from her assigned sex at 23, has been living in a gender role that aligns with her gender identity since 2017, and began estrogen-based hormone therapy 8/01/2017. She has consistently been in my care since that time. Despite these interventions, Ms. Patient continues to experience gender dysphoria. Her symptoms have manifested as anxiety, depression, agoraphobia, and overall distress. She has expressed a persistent desire for the procedures collectively referred to as FGCS. Ms. Patient experiences significant specific dysphoria caused by the appearance of the bone structure and soft tissue of her face. These features are a secondary sex characteristic, and if she had not experienced a testosterone-induced puberty, the visible appearance of these features would be different. Unfortunately, estrogen and spironolactone do not alter bone structure.

Ms. Patient experiences assumptions about her transgender status from the general public as a result of this secondary sex characteristic. She states when she interacts with the world, she is constantly misgendered, harassed, and threatened. This has led her to be quite agoraphobic and isolated. Transgender women face the highest rates of suicidality of any other group. Moreover, not being perceived as female leaves her vulnerable to transphobic violence. The 2017 NCAVP Hate Violence Report[2] also shows that transgender women represent the group most highly impacted by hate violence homicides in the US. I believe she would benefit greatly both medically and psychologically from FGCS.

Because your plan would cover this surgery for the purpose of correcting "accidental injury, disease, trauma, treatment of a disease or congenital defect," but does not consider Gender Dysphoria to be a qualifying indication, this denial is discriminatory. Title XIX of the 1965 Social Security Act states that Medicaid Agencies "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.)" Moreover, California's Insurance Gender Non-Discrimination Act has been interpreted by the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) to mean that exclusions of procedures that aid in gender transition are prohibited. We have consulted with the DMHC, the DOI, and the Transgender Law Center (TLC), all of whom have stated this denial is unlawful given the clear medical necessity of this procedure for this client.

Of note, we have submitted Independent Medical Reviews to the DMHC for FGCS denials previously, all of which were overturned and approved by DMHC. They have clearly stated in each of these cases that FGCS for the treatment of gender dysphoria is reconstructive, not cosmetic. It is frustrating that we continue to see denials and exclusions for this service when the DMHC has clearly stated that it is not a cosmetic surgery. This denial is unlawful under California law. We encourage you to proactively change your policy and to overturn this denial so that further action need not be taken with DMHC and the TLC to address this illegal exclusion.

Ms. Patient is medically and psychosocially stable for surgery, and I have no concern for housing instability, substance use, or other disruptions to her recovery. I hereby recommend and refer her for these surgeries. Her treating mental health providers agree that it is medically necessary step in the treatment plan for her gender dysphoria. This is appropriate treatment in accordance with the guidelines from the World Professional Association of Transgender Health (WPATH) Standards of Care ver 7, and she has met all criteria for surgery[4]. **It is not a cosmetic procedure because the purpose is not solely to improve her physical appearance, but instead to surgically alter a secondary sex characteristic, promote her safety and psychological wellbeing, and treat her well-documented gender dysphoria.**

I have enclosed numerous citations of publications that clearly demonstrate the reconstructive nature of FGCS for transgender women, as well as it's efficacy for the treatment of gender dysphoria. It is much safer than the alternative that patients can afford without health funding, free silicone injection[5]. I have also included WPATH's statement that FGCS may also be considered one of the most impactful medically necessary interventions[6].

Thank you,

Physician, MD

1. California State Legislature. "AB 1586 Anti-Discrimination Law for Transgendered Persons." (September 29, 2005): 1283-1297.
2. National Coalition of Anti-Violence Programs (NCAVP). (2016). Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2016. New York, NY: Emily Waters.
3. Pub.L. 89-97, 79 Stat. 1432, Social Security Amendments of 1965
4. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … Zucker, K. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. International Journal of Transgenderism, 13(4), 165–232. https://doi.org/10.1080/15532739.2011.700873
5. Hage, J. J., Kanhai, R. C. J., Oen, A. L., van Diest, P. J., & Karim, R. B. (2001). The Devastating Outcome of Massive Subcutaneous Injection of Highly Viscous Fluids in Male-to-Female Transsexuals. *Plastic and Reconstructive Surgery*, 107(3), 734–741.
6. Gail, K. Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the USA. World Professional Association for Transgender Health (WPATH), (Dec. 21, 2016).

Demonstrating Efficacy of Facial Gender Confirming Surgery:
Raffaini, M., Magri, A. S., & Agostini, T. (2016). Full Facial Feminization Surgery: Patient Satisfaction Assessment Based on 180 Procedures Involving 33 Consecutive Patients. *Plastic and Reconstructive Surgery, 137*(2), 438. https://doi.org/10.1097/01.prs.0000475754.71333.f6
Ainsworth, T. A., & Spiegel, J. H. (2010). Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research, 19*(7), 1019– 1024. https://doi.org/10.1007/s11136-010-9668-2
Berli, J. U., Capitán, L., Simon, D., Blanbond-Langner, L., Plemons, E., & Morrison, S. D. (2017). Facial gender confirmation surgery—review of the literature and recommendations for Version 8 of the WPATH Standards of Care. *International Journal of Transgenderism, 18*(3), 264– 270. https://doi.org/10.1080/15532739.2017.1302862
Morrison, S. D., Vyas, K. S., Motakef, S., Gast, K. M., Chung, M. T., Rashidi, V., … Cederna, P. S. (2016). Facial Feminization: Systematic Review of the Literature. *Plastic and Reconstructive Surgery, 137*(6), 1759. https://doi.org/10.1097/PRS.0000000000002171

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CONCLUSION

Overturning an insurance denial of a gender affirming surgery can have far-reaching effects, creating access not only for that one patient, but also setting precedent for many others to be able to access that particular intervention. Anyone assisting with the insurance authorization process, including professionals in surgical, primary care, and behavioral health fields can benefit from increased awareness of appeals processes and effective tactics for writing appeal letters.