



Trans Health Project

Working for Transgender Equal Rights

Health Insurance - Understanding a Denial

It's essential to understand the reason for a denial because it affects how you'll need to respond. If the insurance company denies surgery because there is an exclusion for all transgender-related surgery, that's very different than if they say the surgery is "cosmetic."

Review each type of denial by expanding the buttons below.

Once you understand the reason for the denial, you can move on to learn about [Appealing a Denial](#).

Gender Marker Mismatches

Sex-specific care such as gynecological visits, contraception, or prostate exams may be denied if the service doesn't seem to match the gender you are listed as with your insurance. These are computer-generated denials designed to prevent errors or fraud. These can typically be resolved without going through the formal appeals process.

What providers can do

Providers can prevent these denials from occurring by using modifier codes that flag for the insurance company that something that might look like an error isn't. These codes originate in the Medicare context, but they are used in Medicaid and private insurance as well. Some insurance companies have specific billing guidance about transgender patients.

Modifier codes

- Practitioners and non-physician practitioners can append modifier "-KX" to with procedure or diagnosis codes that are sex specific. Modifier KX should be billed on the claim line with the sex/procedure or sex/diagnosis conflict.
- Institutional providers can add the condition code "45" to the appropriate claim field to indicate a sex-specific service. This claim-level condition code alerts the insurer that the sex/procedure or sex/diagnosis conflict is not an error, allowing the sex-related aspect to be bypassed.

If a provider has not used one of the modifiers, the explanation of benefits may come back saying that additional information is requested. Providers can promptly provide that information so that the claim can be approved.

What patients can do

If you are seeking a sex-specific service, make sure your provider has your correct sex as listed with your insurance so that they know if they need to use a modifier code. You can also let the billing staff know about the option to use modifier codes. If the provider doesn't see a lot of trans patients, they may not be familiar with using those codes.

If you have already received a denial, you can sometimes call the number on the back of your card and just explain why the service should not have been denied.

Changing gender markers with insurance

The sex designation on your insurance records will show up at places such as pharmacies, so it is generally best to update the sex to ensure your privacy and eliminate confusion. Insurance companies typically only offer binary sex designations at this time. People have reported that insurance companies have changed the sex designation even without your asking when you submit a name change to them, so be aware of that if you do not want to update the sex designation.

If you are applying for a plan on the Marketplace, they will use the sex you have listed with Social Security on your application, so change it with Social Security first if need be.

Transgender people often hesitate to update their sex designation with insurance due to concerns around getting sex-specific or transgender-related care covered. For example, if a transgender man is already listed as "male" how will he get coverage for a hysterectomy? What matters for insurance coverage, however, is the diagnosis and procedure codes, not someone's administrative sex as recorded by the insurance company. If transgender-related care is not excluded under your plan, then a medically necessary hysterectomy would be covered, regardless of sex designation.

Sometimes people are told they have to change their sex designation *back* in order to access a sex-specific service. This is not accurate. As explained above, a modifier code can be used to process the claim. If an insurance company representative tells you that you need to change your sex designation in order to access care, ask to speak with their supervisor to get more accurate information. If that does not resolve the situation, you can try [filing a civil rights complaint](#) with the insurance company.

Medical Necessity Denials

You can identify medical necessity denials because the denial letter will say the service was considered to be "not medically necessary" or that it was excluded under the "cosmetic" exclusion. Or both!

These are the types of denials that occur when the plan covers transgender-related care, and the insurance company applies its [clinical criteria](#) to determine if the services are medically necessary *for you*. Only, unfortunately, many of those clinical criteria don't actually give people a chance to have their care evaluated on an individualized basis. Many contain language deeming certain services, such as facial surgeries, voice surgeries, or breast augmentation to be automatically denied as "cosmetic." Age restrictions for people under 18 are also still common in these clinical criteria.

The way to challenge these denials is to demonstrate in the appeals process that (1) the service is medical necessity *for you* and (2) the service is recognized *in general* as a medically necessary treatment for gender dysphoria. If you are confident that the care was denied under plan exclusions for care that is "cosmetic" or "not medically necessary," and not due to the other types of exclusions described below, you can safely proceed with the appeals process.

Blanket Exclusion in Plan Document

If your care has been denied under a blanket transgender exclusion, you will want to contact a legal advocate right away to understand what your options are. You can recognize these types of denials because the denial letter will cite a plan exclusion for all transgender-related care, such as an exclusion for "sex change," "sex transformation," or "gender reassignment," or it will simply state that the service is not a covered benefit under your plan.

With these types of denials, **it doesn't matter if you can prove that the care you need is medically necessary**, they will still deny coverage under the exclusion. If you go through the appeals process

instead of directly challenging the exclusion, you will likely waste valuable time as exclusions typically can't be challenged through the normal appeals process.

If you have been denied care due to a blanket transgender exclusion, [contact us](#) to discuss your options. If your care has been denied for other reasons, it's safe to proceed with the appeals process.

Targeted Exclusion in Plan Document

This is similar to a [blanket exclusion](#), but in this case the plan explicitly lists gender dysphoria treatment as covered. However, there will be also certain limitations on coverage right in the plan document. For example, it may only list explicit coverage for genital surgeries and mastectomy. Or it may have a requirement that people be at least age 18. Or it may direct you to the exclusions section where the plan may explicitly exclude facial surgeries, voice surgeries, or breast augmentation.

It may be hard to distinguish this type of denial from a medical necessity denial based on the insurance company's clinical criteria, so it's important to thoroughly [review your plan document](#) to know if there are any exclusions in the plan itself.

The difference between these denials and medical necessity denials is that, as with blanket exclusions, **it doesn't matter if you can prove that the care you need is medically necessary**, they will still deny coverage under the exclusion. If you go through the appeals process instead of directly challenging the exclusion, you will likely waste valuable time as exclusions typically can't be challenged through the normal appeals process.

If you have been denied care due to a targeted transgender exclusion, [contact us](#) to discuss your options. If your care has been denied for other reasons, it's safe to proceed with the appeals process.

Care Sought Under a Different Diagnosis

If there is a [blanket transgender exclusion](#) in your plan, be very cautious about getting potentially transgender-related care covered using a different diagnosis. We have seen cases where a person has gotten a hysterectomy preauthorized for a different legitimate medically necessary reason, such as pelvic pain, but then the insurance company refuses to pay citing the transgender exclusion. If there is a transgender exclusion in your plan, it is best to [seek legal counsel](#) before proceeding with a surgery that could be deemed to be transgender-related even if that is not the reason you need the surgery.

Content last updated on Jul 14, 2021 - PDF generated from: <https://transhealthproject.org/trans-health-insurance-tutorial/understanding-denials/> on Dec. 10, 2025.

If you find this helpful, please consider making a donation at <https://transgenderlegaldefense.networkforgood.com> to support our work.

Copyright © 2024 Advocates For Trans Equality, Inc. | Tel: (202) 642-4542