Payment Policy: Billing Requirements for Transgender Services

Reference Number: LA.PP.047
Product Types: ALL
Effective Date: 08/2020 Coding Implications
Last Review Date: 08/2022~~0~~ Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
This policy describes billing requirements for transgender services when a gender-specific Current Procedural Terminology (CPT®) code is billed or when transgender services are billed on an institutional (inpatient or outpatient) facility claim.

The purpose of this policy is to define payment criteria for gender-specific procedure codes when billed for members whose recorded gender differs from the gender-specific procedure code billed.

Application
1. Practitioner and Non-physician practitioner claims
2. Outpatient and Inpatient Institutional Claims

Policy Description
Section 1557 of the Office of Civil Rights' "Non-Discrimination in Health Programs and Activities" prohibits covered entities that receive Federal financial assistance from "placing limitations on coverage, or denying a claim for coverage for any health service when the denial or limitation occurs because the individual's sex assigned at birth, gender identity or gender otherwise recorded by the plan or insurer is different from the one to which such services are ordinarily or exclusively available."

Furthermore, covered entities that receive Federal financial assistance are prohibited from automatically rejecting sex-specific procedures and services because of a mismatch between the service billed by the provider and the individual's gender recorded in the insurer's claims processing system.

To prevent inappropriate claim denials when the individual's recorded gender does not match the gender-specific procedure or services billed, Louisiana Healthcare Connections will require the use of a specific billing code modifier and condition code to bypass gender-specific claim edits.

Claims Reimbursement Guidelines
The Centers for Medicare and Medicaid Services (CMS) MLN Matters #MM6638, instructs providers to report condition code 45 (Ambiguous Gender Category) on inpatient or outpatient institutional services that can be subject to gender-specific editing. Physicians and non-physician practitioners should append the modifier –KX to the gender-specific procedure code documented on the procedure code detail line.

Louisiana Healthcare Connections code editing software application will evaluate claims data to determine if an institutional claim contains the condition code 45, or for practitioner and non-

physician practitioner clams, that the modifier –KX is appended to a gender-specific procedure code. When these identifiers are found on the claim or at procedure code detail level, the code editing software will bypass gender edits.

Documentation Requirements

- *Practitioners and non-physician practitioners* should append modifier "-KX" to the gender-specific CPT code at the service line level.
- *Institutional Providers* should add the condition code "45" to the appropriate claim field to indicate a gender-specific service.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 201208, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
KX	Requirements specified in the medical policy have been met.

Condition Code	Descriptor
45	Ambiguous Gender Category

Definitions:

1. Covered Entity: Any health program or activity, any part of which receives funding from the Department of Health and Human Services (HHS) such as hospitals that accept Medicare and doctors that accept Medicaid. As well as the Health Insurance Marketplaces and issuers that participate in those Marketplaces.
2. Gender Identity: A personal conception of oneself as male or female, both or neither.
3. Transgender: of, relating to, or being a person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth.
4. Institutional Providers: Hospitals, Skilled Nursing Facilities, End State Renal Disease providers, Home Health Agencies, hospices, outpatient rehabilitation clinics, Comprehensive Outpatient Rehabilitation Facilities, Community Mental Health Centers, Critical Access Hospitals, Federally Qualified Health Centers, histocompatibility laboratories, Indian Health Service Facilities, organ procurement organizations, Religious Non-Medical Health Care Institutions and Rural Health Clinics.
5. Code Editing Software: A rule-based application that evaluates provider's claims against correct coding principles based on CMS guidelines, the American Medical Association's

current procedural terminology (CPT®) guidelines, reimbursement policies, benefit plans and industry standard coding practices.

6. Practitioner: CMS defines as doctors of medicine; doctors of osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine and doctors of optometry.
7. Non-Physician Practitioner: CMS defines as Physician assistant, Nurse practitioner, Clinical nurse specialist, Certified registered nurse anesthetist, Certified nurse midwife, Clinical psychologist, Clinical social worker, Registered ~~dietitian~~dietitian, or Nutrition professional.

Additional Information
Not Applicable

Related Documents or Resources
1. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6638.pdf
2. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities

References
1. *Current Procedural Terminology (CPT)*®, 20~~18~~20
2. *HCPCS Level II*, 20~~18~~20
3. Centers for Medicare and Medicaid (CMS) Medicare Learning Network MLN Matters, Change Request Number MM6638 (2010)
4. Department of Health and Human Services (DHHS) Nondiscrimination in Health Programs and Activities, 45 CFR Part 92 (2016)

Revision History	
08/15/2020	Converted corporate to local policy.
08/30/2022	Annual Review; Updated dates in the reference section from 2018 to 2020 Removed clinical and added payment policy in "Important Reminder" section

Important Reminder
This ~~clinical policy~~payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this ~~clinical policy~~payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy is consistent with standards of medical practice current at the time that this ~~clinical policy~~payment policy was approved.

The purpose of this ~~clinical policy~~payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This ~~clinical policy~~payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this ~~clinical policy~~payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this ~~clinical policy~~payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This ~~clinical policy~~payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This ~~clinical policy~~payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this ~~clinical policy~~payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This ~~clinical policy~~payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this ~~clinical policy~~payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_