

Payment Policy: Billing Requirements for Transgender Services

Reference Number: CC.PP.047

Product Types: ALL

Effective Date: 01/01/2017

Last Review Date: 02/15/2018

[Coding Implications](#)
[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, the health plan 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.

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The health plan’s 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 claims, 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 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2017 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.

CPT/HCPCS Code	Descriptor
N/A	N/A

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

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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 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)®*, 2018
2. *HCPCS Level II*, 2018
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	
10/29/2016	Initial Policy Draft Created
02/15/2018	Conducted annual review and updated policy template

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage,

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certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This 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 payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This 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 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 policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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