Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Transgender Billing Guidelines

Policy Number: RM027
Last Review: 03/01/2024

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
X Facility

DESCRIPTION:

This policy describes billing requirements for transgender services when a gender-specific Current Procedural Terminology (CPT®) code or International Classification of Diseases, Tenth Revision (ICD-10) diagnosis 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/diagnosis codes when billed for members whose recorded gender differs from the gender-specific procedure/diagnosis code billed.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

To ensure claims are processed appropriately, Paramount will align with CMS to require the use of specific modifiers and/or condition codes.

Paramount allows medically necessary gender-specific services provided to a transgender or intersex member when the service is not otherwise excluded. Paramount requires modifier KX and condition code 45, to be submitted on a claim when there is an apparent conflict between members recorded gender and the gender-

specific service performed.

For facility clams, Paramount requires the provider to report condition code 45 when billing for an inpatient or outpatient service that is gender specific.

For professional claims, Paramount requires a provider to include modifier KX with a procedure/diagnosis code for a gender-specific service.

The KX Modifier is used in the following circumstances:

- The procedure is not typical for the member's gender
- The diagnosis is not typical for the member's gender

The KX modifier is to be used on all claims where the procedure code(s) is gender specific but conflicts with the recorded gender.

Paramount requires providers to follow the appropriate Medicare Program guidance for correctly coding a gender-specific service and diagnosis for a transgender or intersex member.

Related Policies – PG0311 Gender Reassignment Surgery

CODING/BILLING INFORMATION:
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

MODIFIER	DESCRIPTION	NOTES
KX	Requirements specified in the medical policy have been met, should be appended to any gender-specific procedure	This modifier informs Paramount that the procedure is performed on a beneficiary for whom gender-specific editing may apply
CONDITION CODE	**DESCRIPTION**	**NOTES**
45	Gender Incongruence	The presence of this condition code on your claim will allow sex-related edits to be bypassed so your claim can be processed

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 01/01/2024

Date	Explanation & Changes
01/01/2024	• Reimbursement/Billing Policy created
02/01/2024	• Reimbursement/Billing Policy updated to new policy format

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

Industry Standard Review