KX Modifier

Reimbursement Policy ID: RPC.0062.0100

Recent review date: 02/2024

Next review date: 10/2025

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes Keystone First reimbursement criteria for procedures appended with modifier KX, which is used to indicate the provider's confirmation that services are justified by appropriate documentation in the medical record.

Exceptions

N/A

Reimbursement Guidelines

Keystone First will consider services and supplies appended with modifier KX for reimbursement when it is documented in the medical record that the patient's experienced gender differs from their sex assigned at birth. Use of the KX modifier will prevent inappropriate application of gender-specific clinical edits in this situation. (Note: Inpatient and outpatient facility providers who submit claims on form CMS-1450 should also report claim Condition Code 45 for accurate reimbursement.)

Definitions

Condition Code 45 – Gender Incongruence
A person's marked and persistent experience of an incompatibility between that person's gender identity and their sex assigned at birth.

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
IV. Centers for Medicare and Medicaid Services (CMS) 2023-06-08-MLNC, Weekly Edition.
V. CMS Medicare Claims Processing Manual
VI. The National Correct Coding Initiative (NCCI)
VII. Pennsylvania Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section