MEDICAID PROVIDER BULLETIN
March 2018

Billing guidelines for transgender members

Anthem Blue Cross and Blue Shield Medicaid follows CMS guidelines for transgender-related services when claims are billed for a member with an ambiguous gender.

Billing instructions for institutional providers

Institutional providers are to report condition code 45 on any inpatient or outpatient claim related to transgender, ambiguous genitalia or hermaphrodite issues. This claim level condition code should be used by institutional providers to identify these unique claims and also alerts the plan that the gender/procedure or gender/diagnosis conflict is not an error, allowing the sex-related edits to be bypassed.

Billing instructions for physicians and nonphysician practitioners

The KX modifier is to be billed on the detail line only with the procedure code(s) that is gender-specific for transgender, ambiguous genitalia and hermaphrodite beneficiaries.
NOTE: The KX modifier is a multipurpose informational modifier and may also be used in conjunction with other medical policies. Physicians and nonphysician practitioners should use modifier KX with procedure codes that are gender-specific in the particular cases of transgender, ambiguous genitalia and hermaphrodite beneficiaries. Therefore, if a gender/procedure or gender/diagnosis conflict edit occurs, the KX modifier alerts the plan that it is not an error and will allow the claim to continue with normal processing.

Provider action

Claims for some services for members with transgender, ambiguous genitalia and hermaphrodite issues will be denied due to sex-related edits unless these services are billed properly.

Questions

If you have questions about this communication, please contact your Provider Relations representative or Provider Services at **1-855-661-2028**.

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