KX Modifier

Reimbursement Policy ID: RPC.0062.PA02

Recent review date: 11/2023

Next review date: 10/2025

AmeriHealth Caritas VIP Care 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. AmeriHealth Caritas VIP Care 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 but not limited to Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM). Other factors that may affect payment include but are not limited to 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 policies. These factors may supplement, modify, or in some cases supersede reimbursement policies.

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

Policy Overview

This policy describes AmeriHealth Caritas VIP Care 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

AmeriHealth Caritas VIP Care will consider services and supplies appended with modifier KX for reimbursement when documentation in the medical record supports at least one of the following:

- That a 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 should report claim Condition Code 45 for accurate reimbursement.)

- That durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) or physical therapy (PT), speech-language pathology (SLP), and/or occupational therapy (OT) services at and above the published Medicare service cap are medically necessary.

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 Statistical Classification of Diseases and Related Health Problems (ICD), and associated publications and services.
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. CMS Medicare Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
11/2023	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care 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