PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **February 10, 2025**

Subject: **LDH Approved Reimbursement Policy -Diagnostic Procedure Code Gender Guidelines**

Summary: **Policy for Diagnostic Procedure Code Gender Guidelines**

AmeriHealth Caritas Louisiana would like to make you aware of a new policy that has been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guideline will be located at the following link on our website under Reimbursement Policies:
https://www.amerihealthcaritasla.com/provider/resources/index.aspx

Reminder: If your practice is not registered with our website portal-NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert? You can find a complete list of provider alerts on our website's Provider Newsletters and Updates page.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com.

Diagnosis Procedure Code Gender Guidelines

Reimbursement Policy ID: RPC.0031.2100

Recent review date: 11/2023

Next review date: 12/2025

AmeriHealth Caritas Louisiana 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 Louisiana 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 addresses the application of gender edits when diagnosis and procedure code(s) are reported inappropriately for the member's gender. Diagnosis and/or procedure gender conflicts will be considered billing errors for all claim types and will not be reimbursed.

Exceptions

Use of the modifier -KX with condition code 45 on a UB04 claim may result in reimbursement when there is a gender conflict service.

Reimbursement Guidelines

Some ICD-10-CM diagnosis codes apply to only female or male patients. The coding books may denote the gender of a diagnosis with a male ♂ or female ♀ symbol. Additionally, some codes may include the word "male" or "female" in the diagnosis description, while others apply to male or female because of gender specific

terms such as prostate, testes, ovary or vagina. Similarly, International Classification of Diseases, 10th revision, Procedure Classification System ICD-10-PCS and CPT codes may be specific to the biological sex of the patient at birth, for example, codes for hysterectomy and vasectomy procedures.

Claims submitted with diagnosis/gender conflict or procedure/gender conflict will not be reimbursed.

Definitions

Diagnosis code
A diagnosis code is one that is defined as currently active per the ICD-10-CM manual. They are composed of codes with 3, 4, 5, 6, or 7 alpha-numeric characters. A diagnosis code is invalid or incomplete if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

Diagnosis age and/or gender consistency
Diagnosis age and/or gender consistency refers to selecting diagnosis codes, which by definition or nature of the diagnosis, are consistent with age, age group or gender of the patient for whom they are being reported.
Example for definition formatting

Modifier: A one- or two-character code used to indicate that a service has either been altered in some way or that a significant circumstance surrounds that service, and this information needs to be taken in to account for claims processing.

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-CM) and associated publications and services.
IV. International Classification of Diseases, 10th revision, Procedure Classification System (ICD-10-PCS)

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 Louisiana from Policy History section
06/2023	Reimbursement Policy Committee Approval
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section