JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.044
		Effective Date	03/15/2025
		Approval Date	01/06/2025
	Subject **Age and Gender/Sex Based Codes**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Age-Specific Criteria, EPSDT, Gender-Specific Criteria

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory

mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

JHHP will align with CMS, CPT, and other authoritative state and federal guidance, for the appropriate reporting of CPT/ HCPCS codes, diagnosis codes, or modifiers with specific gender/sex or age limitations and specifications. When necessary, JHHP may utilize the guidance published by certain professional medical societies. This policy applies to both participating and nonparticipating providers, who submit claims to JHHP on a CMS-1500 claim forms or UB-04 or their electronic equivalents.

III. POLICY STATMENT

This policy provides basic reimbursement guidance for the reporting of CPT/HCPCS codes, diagnosis codes, or modifiers with specific age or gender/sex limitations, rendered within the provider's scope of practice, under state and federal law. Codes applicable to this policy must be billed in accordance with the member's plan and coverage criteria, on the date of service. Each line of business possesses its own unique guidelines for benefit and payment purposes. As such, JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. JHHP will process claims assigned with age limitations and gender/sex designations, based on the code's description.
2. JHHP may reject or return claims inappropriately if it appears there's a mismatch between the procedure or diagnosis code and the reported gender/sex of the patient.
3. JHHP will utilize code-editing programs and post-pay algorithms to:
   i. Identify codes or modifiers reported with the inappropriate age of a patient;
   ii. Identify codes or modifiers reported with the inappropriate gender/sex of a patient

- Examples:
  - *Reporting CPT 99384 (adolescent, well visit) for a patient who is one year of age, will deny.*
  - *Reporting CPT 58150 (total abdominal hysterectomy) reported for a patient who is male, may be denied.*

2. In certain situations, use of the modifier KX alerts us that the gender/sex procedure or diagnosis conflict is not an error and will allow for the claim to be processed.
3. Report Condition Code 45, on UB-04, to indicate that the gender/sex procedure or diagnosis conflict is not an error; this will allow the claim to continue to be processed.
4. All supporting documentation must be maintained in the patient's medical record and made available to JHHP upon request. All claims are subject to review.

5. Providers are responsible to verify coverage and benefits, or if a prior authorization or other requirements are mandatory, prior to services being rendered. Authorizations are not a guarantee of payment.
6. JHHP plans may conduct medical record documentation reviews on a randomly selected sample of primary care practitioners or providers who deliver services outside their regular scope of practice or assigned specialty.
   i. Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.
7. Services or tests determined to be experimental, investigational, or unproven (E/I/U) by JHHP are not eligible for reimbursement.

V. EXCLUSIONS and EXEMPTIONS

PPMCO: JHHP will process and will reimburse Priority Partner claims in accordance to the Code of Maryland Regulations (COMAR) and Maryland Department of Health (MDH). Please consult the authoritative guidance found in these manuals to obtain additional, specific information on policy, benefits, and coverage not outlined in this policy.

- Priority Partner aligns with the MDH Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program guidance, which provides certain benefits for our members from birth up to age 21. JHHP will process and pay claims in accordance with this program. Please refer to EPSDT and Priority Partners for additional information.
- JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
- Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

USFHP: JHHP processes and reimburses claims in accordance with the rules and regulations outlined in the TRICARE manuals and the TRICARE List of HCPCS Codes with Age/Gender Restrictions. Please refer to the applicable manuals for additional guidance not addressed in this policy.

- In compliance with Executive Order (EO) 14187 and the amended National Defense Authorization Act for 2025 (*effective December 23, 2024, for members under the age of 18, and March 13, 2025, for members who are 18 years of age*), JHHP may deny certain claims related to medical interventions for the treatment of gender dysphoria provided to a member under the age of 18. Examples include, but are not limited to:
  - The use of puberty blockers, including gonadotropin-releasing hormone (GnRH) agonists and other interventions, to delay the onset or progression of normally timed puberty in an individual who does not identify as his or her sex;
  - The use of sex hormones, such as androgen blockers, estrogen, progesterone, or testosterone, to align an individual's physical appearance with an identity that differs from his or her sex.

VI. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Condition Code 45	For the purpose of this policy, this claim level condition code should be used by providers to identify these unique claims and also allows the sex related edits to be by-passed. The KX modifier should override any gender specific edits when condition code 45 is present and allow the service to continue normal processing.

Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).
Scope of Practice	Scope of practice refers to those activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity.

Modifiers

Modifier	Definition
63	Procedure performed on infants less than 4 kg. Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number.
KX	For the purpose of this policy, the KX modifier is an informational modifier. The use of this modifier will alert JHHP that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, but should have such editing by-passed for the member. The use of this modifier should override any gender specific edits for procedure codes billed with the KX modifier and allow the service to continue normal processing.

VII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- CMS ICD-10-CM Guidelines
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 25- Completing and Processing the Form CMS 1450-Data Set
- Medicare Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set
- Medicare Claims Processing Manual CH. 32– Billing Requirements for Special Services
- MLN Weekly Edition 2023-06-08| CMS
- TRICARE List of HCPCS Codes with Age/Gender Restrictions
- TRICARE Reimbursement Manual

VIII. APPROVALS

Date	Review/Revision	Reason For Modification	Approved By

1/06/2025	New	New policy	Reimbursement, Authorization and Coding Committee (RAC)

IX. POLICY NOTIFICATION CHART

	Yes/No	If yes in 2nd column, notify the following department of policy revisions:
Does this policy relate to NCQA?	No	Quality Improvement
Does this policy relate to Qlarant/MDH requirements?	No	Quality Improvement
Does this policy relate to DHA contractual requirements?	No	USFHP Administration