



Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict - JA6638

Note: MLN Matters® article MM6638 was revised to change the Change Request (CR) release date, transmittal number, and the Web address for accessing CR6638.

Related CR Release Date: December 18, 2009 **Revised**

Date Job Aid Revised: December 23, 2009

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

Key Words MM6638, CR6638, R1877CP, Gender

Contractors Affected

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Fiscal Intermediaries (FIs)
- Medicare Carriers

Provider Types Affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare Carriers, FIs, and/or A/B MACs for services provided to Medicare beneficiaries are affected.



CR6638 provides instructions for completing Part A and Part B claims for gender specific services for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Provider Needs to Know...

- For Part A claims processing, institutional providers should report condition code 45 (Ambiguous Gender Category) on inpatient or outpatient services for affected beneficiaries where the service performed is gender specific (i.e., services that are considered female or male only).
- This claim level condition code should be used by providers to identify these unique claims and to allow the sex related edits to be processed correctly by Medicare systems

and allow the service to continue normal processing.

- Payment will be made if the coverage and reporting criteria have been met for the service.
 - The **KX modifier**, which is defined as “Requirements specified in the medical policy have been met”, is a multipurpose informational modifier for Part B professional claims.
 - In addition to its other existing uses, the KX modifier should also be used to identify services that are gender specific (i.e., services that are considered female or male only) for affected beneficiaries on claims submitted by physicians and non-physician practitioners to Medicare Carriers and MACs.
 - For Part B professional claims, physicians and non-physician practitioners should bill the KX modifier on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries.
 - Use of the KX modifier will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing.
 - Payment will be made if the coverage and reporting criteria have been met for the service.
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Background

- Claims for some beneficiaries are being rejected by Medicare systems due to gender specific edits. This is resulting in inappropriate denials for Part A and Part B claims.
 - As a result of the number of subject claims received that are being denied due to sex/diagnosis and sex/procedure edits, the National Uniform Billing Committee approved **condition code 45 (Ambiguous Gender Category)** to identify these unique claims and to allow the sex related edits to be processed correctly.
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**Operational
Impact**

N/A

**Reference
Materials**

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6638.pdf> on the CMS website.

The official instruction (CR6638) issued regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1877CP.pdf> on the CMS website.
