CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1877	**Date: December 18, 2009**
	Change Request 6638

Transmittal 1877, dated December 18, 2009 rescinds and replaces, Transmittal 1839, dated October 28, 2009 to remove all Medicare Code Editor (MCE) language, because MCE can't make the required changes.

Subject: Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict

I. SUMMARY OF CHANGES: As the result of transgender and hermaphrodite issues, claims for some beneficiaries are rejecting the IOCE, and CWF due to gender specific edits. This is resulting in inappropriate denials for Part A and Part B claims.

New / Revised Material
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	25/75.2/Form Locators 16-30
N	32/Table of Contents
N	32/240/Special Instructions for Services with a Gender/Procedure Conflict
N	32/240.1/Billing Instructions for Institutional Providers
N	32/240.2/Billing Instructions for Physicians and Non-Physician Practitioners

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1877	Date: December 18, 2009	Change Request: 6638

Transmittal 1877, dated December 18, 2009 rescinds and replaces, Transmittal 1839, dated October 28, 2009 to remove all Medicare Code Editor (MCE) language, because MCE can't make the required changes.

SUBJECT: Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict.

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background: As the result of an increasing number of claims that are denied due to sex/diagnosis and sex/procedure edits, claims for some transgender and hermaphrodite beneficiaries are rejecting out of the Integrated Outpatient Code Editor (IOCE) and the Common Working File (CWF).

B. Policy: For Part A claims processing, institutional providers shall report condition code 45 (Ambiguous Gender Category) on any outpatient claim related to transgender or hermaphrodite issues. 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 CWF shall override any gender specific edits when condition code 45 is present and allow the service to continue normal processing.

For Part B claims processing, the KX modifier shall be billed on the detail line with any procedure code(s) that are gender specific. The definition of the KX modifier is: Requirements specified in the medical policy have been met. Use of the KX modifier will alert the MAC 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 beneficiary. The CWF shall override any gender specific edits for procedure codes billed with the KX modifier and allow the service to continue normal processing.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6638.1	Medicare contractors shall recognize Condition Code 45.	X		X		X	X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6638.2	FISS shall provide the ability to transmit a flag based on the presence of Condition Code 45 on the IOCE input record to bypass sex-related edits in the IOCE.						X				IOCE
6638.3	Contractors shall allow informational modifier KX to be billed with any procedure code that could potentially receive a gender specific edit.	X			X					X	
6638.4	Contractors shall override any gender specific edits (gender/procedure conflict or gender/diagnosis conflict) that occur for a given procedure code if the KX modifier is billed with that code, and allow the claim to continue normal processing.	X			X					X	
6638.5	CWF shall allow any sex-related error codes to be overridden when condition code 45 or the KX modifier is present.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6638.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): For Part A claims processing, contact Diana Motsiopoulos at 410-786-3379, or send an e-mail to Diana.motsiopoulos@cms.hhs.gov
For Part B claims processing, contact Kathleen Kersell at 410-786-2033, or send an e-mail to kathleen.kersell@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Project Officer and Contract Manager.

VI. FUNDING

Section A:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

75.2 - Form Locators 16-30

(Rev. 1877, Issued: 12-18-09, Effective: 04-01-10, Implementation: 04-05-10)

FL 16 – Discharge Hour

Not Required.

FL 17 – Patient Status

Required. (For all Part A inpatient, SNF, hospice, home health agency (HHA) and outpatient hospital services.) This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care.
03	Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05). Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions. **Definition Change Effective 4/1/08**: Discharged/Transferred to a Designated Cancer Center or Children's Hospital.
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).
07	Left against medical advice or discontinued care
08	Reserved for National Assignment
*09	Admitted as an inpatient to this hospital
10-19	Reserved for National Assignment
20	Expired (or did not recover - Religious Non Medical Health Care Patient)
21	Discharged/transferred to Court/Law Enforcement
22-29	Reserved for National Assignment
30	Still patient or expected to return for outpatient services
31-39	Reserved for National Assignment
40	Expired at home (Hospice claims only)

Code	Structure
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a federal health care facility. (effective 10/1/03) Usage note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration (VA) hospital or VA hospital or a VA nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
44-49	Reserved for national assignment
50	Discharged/transferred to Hospice - home
51	Discharged/transferred to Hospice - medical facility
52-60	Reserved for national assignment
61	Discharged/transferred within this institution to a hospital based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to long term care hospitals
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)
67-69	Reserved for national assignment
70	Discharge/transfer to another type of health care institution not defined elsewhere in the code list. (effective 4/1/08)
71-99	Reserved for national assignment

*In situations where a patient is admitted before midnight of the third day following the day of an outpatient diagnostic service or service related to the reason for the admission, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began longer than 3 days earlier or were unrelated to the reason for admission, such as observation following outpatient surgery, which results in admission.

FLs 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28 - Condition Codes

Situational. The provider enters the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period.

Code	Title	Definition
02	Condition is Employment Related	Patient alleges that the medical condition causing this episode of care is due to environment/events resulting from the patient's employment.
03	Patient Covered by Insurance Not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates bill is submitted for informational purposes only. Examples would include a bill submitted as a utilization report, or a bill for a beneficiary who is enrolled in a risk-based managed care plan and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed	The provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance	Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the patient's first 30 months of end stage renal disease entitlement.
07	Treatment of Non-terminal Condition for Hospice Patient	The patient has elected hospice care, but the provider is not treating the patient for the terminal condition and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	The beneficiary would not provide information concerning other insurance coverage. The FI develops to determine proper payment.
09	Neither Patient Nor Spouse is Employed	In response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	In response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer sponsored or provided health insurance that covers the patient.

Code	Title	Definition
11	Disabled Beneficiary But no Large Group Health Plan (LGHP)	In response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. The CMS will assign as needed for FI use. Providers will not report.
15	Clean Claim Delayed in CMS's Processing System (Medicare Payer Only Code)	The claim is a clean claim in which payment was delayed due to a CMS processing delay. Interest is applicable, but the claim is not subject to CPE/CPT standards.
16	SNF Transition Exemption (Medicare Payer Only Code)	An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
17	Patient is Homeless	The patient is homeless.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits that does not have his/her father's last name.
20	Beneficiary Requested Billing	Provider realizes services are non-covered level of care or excluded, but beneficiary requests determination by payer. (Currently limited to home health and inpatient SNF claims.)
21	Billing for Denial Notice	The provider realizes services are at a noncovered level or excluded, but it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility	Patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole Community Hospitals only). The patient was referred for a diagnostic laboratory test. The provider uses this code to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP	In response to development questions, the

Code	Title	Definition
	is Secondary to Medicare	patient and/or spouse indicated that one or both are employed and that there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	In response to development questions, the patient and/or family member(s) indicated that one or more are employed and there is group health insurance from an LGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part time employees; or (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
31	Patient is a Student (Full-Time - Day)	Patient declares that they are enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that they are enrolled in a cooperative/work study program.
33	Patient is a Student (Full-Time - Night)	Patient declares that they are enrolled as a full-time night student.
34	Patient is a Student (Part-Time)	Patient declares that they are enrolled as a part-time student.
Accommodations		
35	Reserved for National Assignment	Reserved for National Assignment.

Code	Title	Definition
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) The hospital temporarily placed the patient in a special care unit because no general care beds were available. Accommodation charges for this period are at the prevalent semi-private rate.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) The patient was assigned to ward accommodations at their own request.
38	Semi-private Room Not Available	(Not used by hospitals under PPS.) Either private or ward accommodations were assigned because semi-private accommodations were not available.

NOTE: If revenue charge codes indicate a ward accommodation was assigned and neither code 37 nor code 38 applies, and the provider is not paid under PPS, the provider's payment is at the ward rate. Otherwise, Medicare pays semi-private costs.

39	Private Room Medically Necessary	(Not used by hospitals under PPS.) The patient needed a private room for medical reasons.
40	Same Day Transfer	The patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization	The claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).
42	Continuing Care Not Related to Inpatient Admission	Continuing care plan is not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Post Discharge Window	Continuing care plan was related to the inpatient admission but the prescribed care was not provided within the post discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. (Note: For Medicare, the change in patient status from

Code	Title	Definition
		inpatient to outpatient is made prior to discharge or release while the patient is still a patient of the hospital).
45	*Ambiguous Gender Category*	*Claim indicates patient had ambiguous gender characteristics (e.g. transgendered or hermaphrodite).*
46	Non-Availability Statement on File	A nonavailability statement must be issued for each TRICARE claim for nonemergency inpatient care when the TRICARE beneficiary resides within the catchment area (usually a 40-mile radius) of a Uniformed Services Hospital.
47		Reserved for TRICARE
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "TRICARE – authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49	Product replacement within product lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product replacement for known recall of a product	Manufacturer or FDA has identified the product for recall and therefore replacement.
51-54		Reserved for national assignment
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	The patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	The patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Terminated Managed Care Organization Enrollee	Code indicates that patient is a terminated enrollee in a Managed Care Plan whose three-day inpatient hospital stay was waived.
59	Non-primary ESRD Facility	Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than

Code	Title	Definition
		his/her primary ESRD dialysis facility. Effective 10/01/04
60	Operating Cost Day Outlier	Day Outlier obsolete after FY 1997. (Not reported by providers, not used for a capital day outlier.) PRICER indicates this bill is a length-of-stay outlier. The FI indicates the cost outlier portion paid value code 17.
61	Operating Cost Outlier	(Not reported by providers, not used for capital cost outlier.) PRICER indicates this bill is a cost outlier. The FI indicates the operating cost outlier portion paid in value code 17.
62	PIP Bill	(Not reported by providers.) Bill was paid under PIP. The FI records this from its system.
63	Payer Only Code	Reserved for internal payer use only. CMS assigns as needed. Providers do not report this code. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirements of 42 CFR 411.4(b) for payment
64	Other Than Clean Claim	(Not reported by providers.) The claim is not "clean." The FI records this from its system.
65	Non-PPS Bill	(Not reported by providers.) Bill is not a PPS bill. The FI records this from its system for non-PPS hospital bills.
66	Hospital Does Not Wish Cost Outlier Payment	The hospital is not requesting additional payment for this stay as a cost outlier. (Only hospitals paid under PPS use this code.)
67	Beneficiary Elects Not to Use Lifetime Reserve (LTR) Days	The beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use Lifetime Reserve (LTR) Days	The beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts.
69	IME/DGME/N&A Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health.
70	Self-Administered Anemia	Code indicates the billing is for a home

Code	Title	Definition
	Management Drug	dialysis patient who self administers an anemia management drug such as erythropoetin alpha (EPO) or darbepoetin alpha.
71	Full Care in Unit	The billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	The billing is for a patient who managed their own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	The bill is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	The bill is for a patient who received dialysis services at home.
75	Home 100-percent	Not used for Medicare.
76	Back-up In-Facility Dialysis	The bill is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full	The provider has accepted or is obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by Managed Care Plan	The bill is for a newly covered service under Medicare for which a managed care plan does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off-Site	Physical therapy, occupational therapy, or speech pathology services were provided off-site.
80	Home Dialysis-Nursing Facility	Home dialysis furnished in a SNF or Nursing Facility.
81-99		Reserved for National assignment.

Special Program Indicator Codes Required

The only special program indicators that apply to Medicare are:

A0	TRICARE External	Not used for Medicare.

Code	Title	Definition
	Partnership Program	
A3	Special Federal Funding	This code is for uniform use by State uniform billing committees.
A5	Disability	This code is for uniform use by State uniform billing committees.
A6	PPV/Medicare Pneumococcal Pneumonia/Influenza 100% Payment	Medicare pays under a special Medicare program provision for pneumococcal pneumonia/influenza vaccine (PPV) services.
A7-A8		Reserved for national assignment
A9	Second Opinion Surgery	Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
AA	Abortion Performed due to Rape	Self-explanatory – Effective 10/1/02
AB	Abortion Performed due to Incest	Self-explanatory – Effective 10/1/02
AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Self-explanatory – Effective 10/1/02
AD	Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself	Self-explanatory – Effective 10/1/02
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Self-explanatory – Effective 10/1/02
AF	Abortion Performed due to Emotional/psychological Health of the Mother	Self-explanatory – Effective 10/1/02
AG	Abortion Performed due to Social Economic Reasons	Self-explanatory – Effective 10/1/02
AH	Elective Abortion	Self-explanatory – Effective 10/1/02
AI	Sterilization	Self-explanatory – Effective 10/1/02
AJ	Payer Responsible for Copayment	Self-explanatory – Effective 4/1/03
AK	Air Ambulance Required	For ambulance claims. Air ambulance required – time needed to transport poses a

Code	Title	Definition
		threat – Effective 10/16/03
AL	Specialized Treatment/bed Unavailable	For ambulance claims. Specialized treatment/bed unavailable. Transported to alternate facility. – Effective 10/16/03
AM	Non-emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required. Effective 10/16/03
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening. Effective 1/1/04
AO-AZ		Reserved for national assignment
B0	Medicare Coordinated Care Demonstration Program	Patient is participant in a Medicare Coordinated Care Demonstration.
B1	Beneficiary is Ineligible for Demonstration Program	Full definition pending
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the Ambulance Fee Schedule
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable Law. – Effective 10/16/03
B4	Admission Unrelated to Discharge	Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004. Effective January 1, 2005
B5-BZ		Reserved for national assignment
QIO Approval Indicator Codes		
C1	Approved as Billed	Claim has been reviewed by the QIO and has been fully approved including any outlier.
C3	Partial Approval	The QIO has reviewed the bill and denied some portion (days or services). From/Through dates of the approved portion of the stay are shown as code “M0” in FL 36. The hospital excludes grace days and any period at a non-covered level of care (code “77” in FL 36 or code “46” in FL 39-41).
C4	Admission Denied	The patient’s need for inpatient services was reviewed and the QIO found that none of the

Code	Title	Definition
		stay was medically necessary.
C5	Post-payment Review Applicable	Any medical review will be completed after the claim is paid.
C6	Preadmission/Pre-procedure	The QIO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
C8-CZ		Reserved for national assignment
Claim Change Reasons		
D0	Changes to Service Dates	Self-explanatory
D1	Changes to Charges	Self-explanatory
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Code	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/HCPCS/HIPPS Rate Codes (FL44)
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Changes In ICD-9-CM Diagnosis and/or Procedure Code	Use for inpatient acute care hospital, long-term care hospital, inpatient rehabilitation facility and inpatient Skilled Nursing Facility (SNF).
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (Includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)
D7	Change to Make Medicare the Secondary Payer	Self-explanatory
D8	Change to Make Medicare the Primary Payer	Self-explanatory
D9	Any Other Change	Self-explanatory
DA – DQ		Reserved for national assignment
DR	Disaster related	Used to identify claims that are or may be impacted by specific payer/health plan

Code	Title	Definition
		policies related to a national or regional disaster.
DS – DZ		Reserved for national assignment
E0	Change in Patient Status	Self-explanatory
E1 – FZ		Reserved for national assignment
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center. The visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain. Proper reporting of Condition Code G0 allows for payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.
G1 – GZ		Reserved for national assignment
H0	Delayed Filing, Statement Of Intent Submitted	Code indicates that Statement of Intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation.
H1-LZ		Reserved for national assignment
M0	All Inclusive Rate for Outpatient Services (Payer Only Code)	Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient.
M1-MW		Reserved for payer assignment
MX	Wrong Surgery on Patient (Payer Only Code)	Code, assigned by the contractor, indicating the wrong surgery was performed on the patient.
MY	Surgery on Wrong Body Part (Payer Only Code)	Code, assigned by the contractor, indicating surgery was performed on the wrong body part.
MZ	Surgery on Wrong Patient (Payer Only Code)	Code, assigned by the contractor, indicating surgery was performed on the wrong patient.

Code	Title	Definition
N0-OZ		Reserved for national assignment
P0-PZ		Reserved for national assignment. FOR PUBLIC HEALTH DATA REPORTING ONLY
Q0-VZ		Reserved for national assignment.
W0	United Mine Workers of America (UMWA) Demonstration Indicator	United Mine Workers of America (UMWA) Demonstration Indicator ONLY
W1-ZZ		Reserved for national assignment.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev. 1877, 12-18-09)

240 – Special Instructions for Services with a Gender/Procedure Conflict

(Rev. 1877, Issued: 12-18-09, Effective: 04-01-10, Implementation: 04-05-10)

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

The National Uniform Billing Committee (NUBC) has approved condition code 45 (Ambiguous Gender Category) as a result of the increasing number of claims received that are denied due to sex/diagnosis and sex/procedure edits. This claim level condition code should be used by institutional providers to identify these unique claims and alerts the fiscal intermediary that the gender/procedure or gender/diagnosis conflict is not an error allowing the sex related edits to be by-passed.

The KX modifier (Requirements specified in the medical policy have been met) is now a multipurpose informational modifier and will also be used identify services for transgender, ambiguous genitalia, and hermaphrodite beneficiaries in addition to its other existing uses. Physicians and non-physician 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 MAC that it is not an error and will allow the claim to continue with normal processing.

240.1 - Billing Instructions for Institutional Providers

(Rev. 1877, Issued: 12-18-09, Effective: 04-01-10, Implementation: 04-05-10)

Institutional providers are to report condition code 45 on any inpatient or outpatient claim related to transgender, ambiguous genitalia, or hermaphrodite issues.

240.2 – Billing Instructions for Physicians and Non-Physician Practitioners

(Rev. 1877, Issued: 12-18-09, Effective: 04-01-10, Implementation: 04-05-10)

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.)