Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Medicare will cover immunizations for H1N1 influenza also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. For more information, go to http://www.cms.gov/About-CMS/Agency-Information/H1N1/index.html on the CMS website.

MLN Matters® Number: MM6638 | Related Change Request (CR) #: 6638

Related CR Release Date: December 18, 2009 | Effective Date: April 1, 2010

Related CR Transmittal #: R1877CP | Implementation Date: April 5, 2010

Note: This article was updated on January 3, 2013, to reflect current Web addresses. This article was previously revised on December 21, 2009, to reflect a revised CR 6638 that was issued on December 18, 2009. The CR release date, transmittal number, and the Web address for accessing CR 6638 were revised in this article. All other information remains the same.

Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict

Provider Types Affected

This article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6638 which provides instructions for completing Part A and Part B claims for gender specific services for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

CAUTION – What You Need to Know

Claims for some beneficiaries are being rejected by Medicare systems due to gender specific edits, and this is resulting in inappropriate denials for Part A and Part B claims. CR 6638 instructs that for Part A claims processing, institutional providers should report condition code 45 (Ambiguous Gender Category) on inpatient or outpatient services that can be subjected to gender specific editing (i.e., services that are considered female or male only) for the above defined beneficiaries. CR 6638 instructs physicians and non-physician practitioners that for Part B professional claims the KX modifier (Requirements specified in the medical policy have been met) should be billed on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Claims for some services for beneficiaries described above may be inadvertently denied due to sex related edits unless these services are billed properly.

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 (NUBC) approved condition code 45 (Ambiguous Gender Category) to identify these unique claims and to allow the sex related edits to be processed correctly.

CR 6638 instructs institutional providers submitting Part A claims to report condition code 45 (Ambiguous Gender Category) on inpatient or outpatient services for effected 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 effected beneficiaries on claims submitted by physicians and non-physician practitioners to Medicare carriers and MACs. 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.

Additional Information

The official instruction, CR 6638, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1877CP.pdf on the CMS website. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.