Diagnosis Procedure Code Gender Guidelines

Reimbursement Policy ID: RPC.0031.0100

Recent review date: 11/2025

Next review date: 12/2026

Keystone First 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. Keystone First 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.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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 modifier KX with condition code 45 on a 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.

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)
V. Centers for Medicare and Medicaid Services (CMS).
VI. The National Correct Coding Initiative (NCCI)
VII. Corresponding Keystone First Clinical Policies.
VIII. Applicable Keystone First manual reference.
IX. Commonwealth of Pennsylvania Medicaid Program guidance.
X. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

11/2025	Reimbursement Policy Committee Approval
10/2025	Annual review • No revisions
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section