



Manual: Reimbursement Policy

Policy Title: **Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service**

Section: Modifiers

Subsection: None

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### Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### Reimbursement Guidelines

#### A. 2015 Addition of Modifiers -X{EPSU}

Effective for dates of service January 1, 2015 and following, Moda Health will accept modifiers XE, XS, XP, and XU and will expect providers to use modifiers XE, XS, XP, and XU in place of modifier 59 when appropriate.

- Modifier 59 should not be used when one of the -X{EPSU} modifiers describes the reason for the distinct procedural service. The -X{EPSU} modifiers are more specific versions of the -59 modifier.
- It is not appropriate to bill both modifier 59 and a -X{EPSU} modifier on the same line.

#### B. Criteria for Separate Reimbursement

1. CPT codes submitted with modifiers XE, XP, XS, XU, or 59 appended will be considered separately reimbursable when all the following apply:
  - a. The clinical edit is eligible for a modifier bypass (e.g. per edit rationale, CCI modifier indicator = "1", etc.).
  - b. CMS policy on the -X{EPSU} modifiers is evolving. If CMS indicates a specific edit may only be bypassed with a specific -X{EPSU} modifier but is not eligible for a bypass with the other -X{EPSU} modifier options or with modifier 59, Moda Health will follow those specific requirement as well.

“For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers.” (CMS<sup>5</sup>)

- c. The CPT code is not considered a bundled component of a more comprehensive procedure (code definitions, standards of medical & surgical practice, etc.).
  - d. The modifier and the code have been submitted in accordance with AMA CPT book guidelines, CPT Assistant guidelines, CMS/NCCI Policy Manual guidelines, and any applicable specialty society guidelines.
  - e. The medical records documentation supports the appropriate use of modifiers XE, XP, XS, XU, or 59.
  - f. The procedure code is eligible for separate reimbursement according to the status indicators on the CMS fee schedule for the relevant provider type (physician fee schedule, ASC, OPPS, etc.).
2. The submission of modifiers XE, XP, XS, XU, or 59 appended to a procedure code indicates that documentation is available in the patient's records which will support the distinct or independent identifiable nature of the service submitted with modifier XE, XP, XS, XU, or 59, and that these records will be provided in a timely manner for review upon request.
  3. Modifiers XE, XP, XS, XU, and/or 59 do not bypass multiple surgery fee reductions, bilateral fee adjustments, or any other administrative policy other than clinical edits.

**C. Appropriate use of modifiers XE, XP, XS, XU, or 59:**

Example	Use	Rationale
Column 1 Code / Column 2 Code - 93015/93040 <u>Procedure # 1:</u> CPT Code 93015 – <i>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report</i> <u>Procedure # 2:</u> CPT Code 93040-XE – <i>Rhythm ECG, one to three leads; with interpretation and report</i>	XE	<ul style="list-style-type: none"> <li>• If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and modifiers 59 or XE should not be used.</li> <li>• If the rhythm ECG is performed at a different encounter than the cardiovascular stress test (before, or after), then 93040 may be reported with modifier XE.</li> </ul> <p style="text-align: right;">(CMS<sup>6</sup>)</p>
Separate surgical operative session on the same date of service (e.g. 8 AM surgery with one procedure, 4 PM surgery with second procedure code).	XE	Separate encounter.

Example	Use	Rationale
<p><i>Example not available. Modifier XP is a little unclear. No CMS example scenarios are found. No other good example scenarios are found.</i></p> <p><b>Note:</b> Like modifier 59, modifier XP should not be appended to an E/M service procedure code; this is not a valid or appropriate procedure/modifier combination. Modifiers -24 or -25 should be used as appropriate instead.</p>	XP	<ul style="list-style-type: none"> <li>• Modifier XP could be used if a cross-provider bundling scenario would apply (not TC/26 bundling), the providers are of different specialties, and the billing office can support that the cross-provider bundling should not apply in this case. <i>No example can be given as this is very uncommon.</i></li> <li>• Modifier XP should not be appended to E/M service codes.</li> </ul>
<p>Column 1 Code / Column 2 Code - 11055/11720</p> <p><u>Procedure # 1, Left forearm:</u> CPT Code 17000 – <i>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion</i></p> <p><u>Procedure # 2, Left upper arm:</u> CPT Code 11102-XS – <i>Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion.</i></p>	XS	<ul style="list-style-type: none"> <li>• Same encounter</li> <li>• Different anatomical site and contralateral structure.</li> <li>• (Note: Modifiers LT or RT cannot be used. No anatomic modifiers are available to use.) (CMS<sup>6</sup>)</li> </ul>

Example	Use	Rationale
<p>Column 1 Code / Column 2 Code - 11055/11720</p> <p><u>Procedure # 1:</u> CPT Code 11055 - <i>Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion</i></p> <p><u>Procedure # 2:</u> CPT Code 11720 – <i>Debridement of nail(s) by any method(s); one to five</i></p>	XS	<ul style="list-style-type: none"> <li>• Modifiers 59 or –X{EPSU} should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared.</li> <li>• If one to four nails are debrided (can append up to 4 modifiers) and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail, then report CPT code 11720 with the appropriate toe modifiers for the one to four toes with nail debridement (e.g. 11720-T1, T2, T3, T4), and report CPT code 11055 with the toe modifier for the different toe with the paring performed (e.g. 11055-T7).</li> <li>• If five nails are debrided (can append a maximum of 4 modifiers) and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail, then report CPT code 11720 with modifier XS, and report CPT code 11055 with the toe modifier for the different toe with the paring performed (e.g. 11055-T7).</li> </ul>
<p>Separate injury (or area of injury in extensive injuries).</p>	XS versus 59	<p>Depending upon your specific circumstances XS or 59 may be most appropriate.</p>
<p>Column 1 Code/Column 2 Code 93453/76000</p> <p><u>Procedure # 1:</u> CPT Code 93453 – <i>Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed</i></p> <p><u>Procedure # 2:</u> CPT Code 10121 – <i>Incision and removal of foreign body, subcutaneous tissues; complicated</i></p> <p><u>Procedure # 3:</u> CPT Code 76000-XU – <i>Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)</i></p>	XU	<ul style="list-style-type: none"> <li>• CPT code 76000 should not be reported and Modifiers 59 or –X{EPSU} should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure.</li> <li>• Modifier –XU may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure, such as to locate the foreign body for CPT 10121.</li> </ul> <p style="text-align: right;">(CMS<sup>6</sup>, Jitendra<sup>7</sup>)</p>

Example	Use	Rationale
<p>Column 1 Code / Column 2 Code - 37220/75710</p> <p><u>Procedure # 1:</u> CPT Code 37220 – <i>Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty</i></p> <p><u>Procedure # 2:</u> CPT Code 75710 – <i>Angiography, extremity, unilateral, radiological supervision and interpretation.</i></p>	XU	<ul style="list-style-type: none"> <li>• If a diagnostic angiography has not been previously performed and based on the result of today's based on the result of the diagnostic angiography a decision is made to perform the revascularization, then 75710-XU may be separately reported.</li> <li>• If a diagnostic angiography has been previously performed, then 75710 may not be separately reported and modifiers XU or 59 may not be used.</li> <li>• If the revascularization is performed and at the end of the procedure an angiography is performed to verify that the revascularization has been successful, this is considered included in the revascularization, and 75710 may not be separately reported and modifiers XU or 59 may not be used.</li> </ul> <p>See CCI Policy Manual, chapter 1, modifier 59 guidelines. (CMS<sup>2</sup>) &amp; (CMS<sup>6</sup>)</p>
<p>Benign skin lesion (0.7 cm) removed from left posterior ribs (11401) and benign skin lesion (0.4 cm) removed from right arm (11400-59).</p>	59	<ul style="list-style-type: none"> <li>• Same encounter</li> <li>• Same organ system and/or structure (skin)</li> <li>• Different lesions.</li> </ul>
<p>Diagnostic mediastinoscopy via midline incision (39400) and thoracoscopy of right lateral lung via lateral incision with biopsy of pleura (32609-XS??).</p> <p>Different organ system (e.g. laparoscopy on separate organ systems).</p>	59	<ul style="list-style-type: none"> <li>• Same encounter</li> <li>• Same organ system (respiratory)</li> <li>• Different incision.</li> </ul>
<p>Colonoscopy with snare removal of polyp in transverse colon (45385) and bipolar cautery of polyp in descending colon (45384-59).</p>	59	<ul style="list-style-type: none"> <li>• Same encounter</li> <li>• Same incision or orifice (rectum)</li> <li>• Different/separate lesions.</li> </ul>

CMS may in the future release further clarification and/or example scenarios for these modifiers. We'll update these examples as new information is made available.

**D. Incorrect use of modifiers XE, XP, XS, XU, or 59:**

1. Procedures in the same anatomical site (e.g. digit, breast, etc.), even with incision lengthening or contiguous incision.

2. CPT identified “separate” procedures performed in the same session, same anatomic site, or orifice.
3. Laparoscopic procedure converted to open procedure.
4. Incisional repairs are part of the global surgical package, including deliveries and cosmetic improvement of a previous scar at the location of the current incision.
5. Contiguous structures in the same anatomic site or organ system. [See Coding Guidelines “Different Organs/Contiguous Structures” and CCI Policy Manual, chapter 1. (CMS <sup>2</sup>)]
6. Modifier XP should not be used to identify two providers of the same specialty in the same clinic to bypass global surgery package rules, new-patient visit edits, or other same-specialty rules.
7. Appending XE, XP, XS, XU, or 59 to Evaluation and Management (E/M) codes instead of using modifiers -24 or -25.

### Codes, Terms, and Definitions

#### Modifier Definitions:

Modifier	Modifier Definition
Modifier 59	<p><b>Distinct Procedural Service:</b> Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.</p> <p><b>Note:</b> Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, see modifier 25.</p>

Effective for dates of service January 1, 2015 and following, CMS is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.” These modifiers are XE, XS, XP, and XU, and collectively they are referred to as -X{EPSU}. The -X{EPSU} modifiers are more selective versions of the -59 modifier. (CMS <sup>4,5</sup>)

Modifier	Modifier Definition
Modifier XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
Modifier XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
Modifier XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
Modifier XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

### Definition of Terms

Term	Definition
Ipsilateral	On the same side; affecting the same side of the body; the opposite of contralateral.  In paralysis, this term is used to describe findings on the same side of the body as the brain or spinal cord lesions producing them.
Contralateral	On the opposite side; originating in or affecting the opposite side of the body, the opposite of homolateral and ipsilateral.

### **Coding Guidelines**

“Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled.” (CMS<sup>2</sup>)

“Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.” (CMS<sup>2</sup>)

### Paired Structures, Ipsilateral versus Contralateral

“It is very important that NCCI-associated modifiers only be used when appropriate. In general these circumstances relate to separate patient encounters, separate anatomic sites or separate specimens. (See subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have modifier indicators of “1” because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when performed on the ipsilateral organ or structure unless there is a specific coding

rationale to bypass the edit. The existence of the NCCI edit indicates that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers generally should not be utilized.” (CMS<sup>2</sup>)

#### Different Procedure or Surgery

“One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe “different procedure or surgery”. The code descriptors of the two codes of a code pair edit consisting of two surgical procedures or two diagnostic procedures usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service.” (CMS<sup>2</sup>)

#### Different Diagnosis

“Use of modifier 59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.” (CMS<sup>2</sup>)

#### Different Organs/Contiguous Structures

“From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site.” (CMS<sup>2</sup>)

“If multiple bacterial blood cultures are performed, including isolation and presumptive identification of isolates, code 87040, *Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)*, should be used to identify each culture procedure performed. Modifier 59 should be appended to the additional procedures performed to identify each additional culture performed as a distinct service.” (AMA<sup>3</sup>)

#### Relationship of Modifiers XE, XP, XS, and XU to Modifier 59

“These modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of the -59 modifier...The -X{EPSU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line.” (CMS<sup>4</sup>)



“Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.” (AMA <sup>1</sup>)

### Cross References

- A. “Clinical Editing.” Moda Health Reimbursement Policy Manual, RPM002.
- B. “Valid Modifier to Procedure Code Combinations.” Moda Health Reimbursement Policy Manual, RPM019.
- C. “Modifier 51 - Multiple Procedure Fee Reductions.” Moda Health Reimbursement Policy Manual, RPM022.

### References & Resources

1. American Medical Association. “Appendix A – Modifiers.” *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E, “Modifiers and Modifier Indicators.”
3. American Medical Association. “Modifier 59”. *CPT Assistant*. Chicago: AMA Press, December 2010, p. 16.
4. CMS. “Specific Modifiers for Distinct Procedural Services.” CMS Manual System, Pub 100-20 One-Time Notification. Transmittal 1422, CR 8863: August 15, 2014.
5. CMS. “Specific Modifiers for Distinct Procedural Services”. MedLearn Matters. MLN Matters® Number: MM8863: August 15, 2014.
6. CMS. “Proper Use of Modifier 59.” MedLearn Matters. MLN Matters® Number: SE1418 Revised: March 2, 2020. Last accessed December 7, 2020.
7. Jitendra M.Sc, CPC. “CPT code 77002, 77003, 77001: Fluoroscopy guidance tips.” American Medical Coding.com. Published: June 1, 2019; Last accessed December 7, 2020. [https://www.americanmedicalcoding.com/coding-fluoroscopy-cpt-codes/#When\\_to\\_use\\_Fluoroscopy\\_CPT\\_code\\_76000\\_and\\_76001](https://www.americanmedicalcoding.com/coding-fluoroscopy-cpt-codes/#When_to_use_Fluoroscopy_CPT_code_76000_and_76001) .

### Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

### **IMPORTANT STATEMENT**

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan,

the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

\*\*\*\*\* The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to [https://www.modahealth.com/medical/policies\\_reimburse.shtml](https://www.modahealth.com/medical/policies_reimburse.shtml) \*\*\*\*\*