Select Health

CODING/REIMBURSEMENT POLICY

DISTINCT PROCEDURAL SERVICE MODIFIERS (59, XE, XP, XS, XU)

Policy # 05
Implementation Date: 1/1/02
Review Dates:
Revision Dates: 7/1/05, 5/9/08, 9/24/14, 1/3/25

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when you should not report certain HCPCS or CPT codes together, in most, or all situations. One purpose of the NCCI PTP edits is to prevent payment for codes that would report overlapping services, except for services that are considered separate and distinct.

A Distinct Procedural Service is defined as a procedure or service that was independent from other non-E/M services performed on the same day. Modifiers 59, XE, XP, XS and XU are valid modifiers on Column 1 and Column 2 codes, and are used to identify procedures/services that are not normally reported together but are appropriate under the circumstances of the patient encounter. When appending a modifier 59 or X" " (E, P, S, U), signed documentation must support the separate session, surgery, procedure, site, organ/organ system, lesion, injury, or incision not ordinarily encountered on the same day by the same provider.

When appropriate, modifiers XE, XP, XS and XU should be used rather than modifier 59. Per CMS, these modifiers provide greater reporting specificity in situations where modifier 59 was used previously. Only use modifier 59 if no other more specific modifier is appropriate. Of note, modifier 59 should never 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 date, see modifier 25.

Modifiers XE, XP, XS, XU: These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be used in lieu of modifier 59 whenever possible.

Upon appeal, consideration should be given for the denied code combination(s) based on the definition and criteria as outlined below in the next section.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Upon appeal, a code combination in which a 59, XE, XP, XS, or XU modifier is used will be reviewed against documentation to verify if the use of the modifier is appropriate. If another modifier better describes the unique service or procedure performed it should be used instead of modifier 59. Additionally, the code(s) must meet one or more of the following criteria to be eligible for payment:

- Be performed at a separate site, and/or
- Be performed on a separate organ system, and/or

- Be performed at a separate session on the same date of service, and/or
- Be a separate incision, excision, lesion, or injury, and/or
    - If separate incisions are used there will need to be a medically necessary indication, and it should be for a different anatomic site. If multiple incisions are necessary to complete a procedure in the same area the 59 modifier is not appropriate.
- Be a distinct and separate service/procedure

If the code(s) do not meet the above listed criteria the code will remain denied.

SELECT HEALTH MEDICARE (CMS)

Select Health Advantage **will follow CMS guidelines**.

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care **will follow the commercial plan policy.**

Distinct Procedural Service Modifiers

Modifier 59	**Distinct Procedural Service:** (This modifier is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances. When billing, report the first code without a modifier. On subsequent lines, report the code with the modifier.) 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. Note: 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 date, see modifier 25.
Modifier XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
Modifier XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
Modifier XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
Modifier XU	Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Sources
1. CMS MLN Fact Sheet "Proper use of modifiers 59, XE, XP, XS & XU", MLN1783722 February 2024. Retrieved from https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf
2. Current Procedural Terminology (CPT®), (2024) – American Medical Association.
3. ICD-10-CM Official Guidelines (2024). Retrieved from https://www.encoderpro.com/epro/rcpDocHandler.do?_a=view&_dk=ICD10_CM_GuidelinesMedicare
4. NCCI 2023 Coding Policy Manual. Chapter 1- General Correct Coding Policies. Retrieved from https://www.cms.gov/files/document/medicare-ncci-policy-manual-2024-chapter-1.pdf

Disclaimer
This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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