Payment Policy: Distinct Procedural Modifiers: XE, XS, XP, & XU

Reference Number: LA.PP.020
Product Types: ALL
Effective Date: 08/2020 Coding Implications
Last Review Date: 07/2023 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
As of January 1, 2015, the American Medical Association (AMA) revised the definition for modifier -59 and established four new subsets of modifier -59. Modifiers -XE, -XS, -XP and -XU. These modifiers should be used in place of modifier -59 (when appropriate) as they are more descriptive, specific versions of modifier -59. Refer to the table on page 2 of this policy for the official descriptions of each subset modifier.

The Centers for Medicare and Medicaid Services (CMS) has indicated that modifier -59 should never be reported routinely or when another modifier more accurately describes the clinical circumstances surrounding the procedure performed.

CMS has directed that these modifiers be used instead of modifier -59 to more specifically define the types of services rendered. Therefore, it is inappropriate to bill both modifier -59 and one of the "X" subset modifiers on the same claim. These changes are being made because of the widespread inappropriate use of modifier -59.

Application
This policy applies to hospital and professional claims.

Reimbursement
Claims Reimbursement Edit

Louisiana Healthcare Connections code auditing software will flag all provider claims billed with modifiers XE, XS, XP and XU for prepayment clinical validation. Clinical validation occurs *prior to* claims payment. Once a claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.

Rationale for Edit
To ensure correct use of modifiers and adherence to correct coding principles.

Documentation Requirements
These modifiers will be reviewed for correct coding in the same manner as modifier -59. Because each of these modifiers represents different clinical scenarios, Louisiana Healthcare Connections will conduct a prepayment review and look for support from the claim and the patient's claim history, as indicated by the modifier used by the provider. For example, for modifier XE, the Plan will determine if the clinical situation is likely to require more than one encounter per day. For modifier XP, the Plan will determine if it is likely the clinical scenarios would require two practitioners and that the practitioners are of different specialties.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
-XE	*Separate Encounter*; A Service That Is Distinct Because It Occurred During A Separate Encounter
-XS	*Separate Structure*; A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
-XP	*Separate Practitioner*; A Service That Is Distinct Because It Was Performed By A Different Practitioner
-XU	*Unusual Non-Overlapping Service*; the Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of the Main Service

References

1. *Current Procedural Terminology (CPT®), 2022*
2. *Centers for Medicare and Medicaid Services (CMS), CMS Manual System and other CMS publications and services*
3. *Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) publications*

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/26/2022	
Annual review; formatting updated.	7/19/2023	9/13/2023

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing

this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.