

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

Reference Number: CC.PP.020

Product Types: ALL

Effective Date: 01/01/2013

Last Review Date: 03/10/2019

[Coding Implications](#)
[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.

- ***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

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 the 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

The Health Plan’s clinical code auditing software will flag all provider claims billed with modifiers **XE, XS, XP and XU** for prepayment clinical validation. Clinical validation occurs

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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 the 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, the Plan 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, we 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 2018, 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	<i>Separate Encounter</i> ; A Service That Is Distinct Because It Occurred During A Separate Encounter
-XS	<i>Separate Structure</i> ; A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
-XP	<i>Separate Practitioner</i> ; A Service That Is Distinct Because It Was Performed By A Different Practitioner
-XU	<i>Unusual Non-Overlapping Service</i> ; the Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of the Main Service

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References

1. *Current Procedural Terminology (CPT®), 2018*
2. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services*
3. *Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications*
4. *American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services*
5. *Optum 360Learning. (2018) Understanding Modifiers. Comprehensive instruction to effective modifier application*

Revision History	
03/08/2017	Converted to new template and conducted review.
03/10/2018	Reviewed and revised the policy.
03/10/2019	Conducted review and updated policy

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. 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. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment 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.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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