# Payment Policy | Modifier 59, XE, XP, XS, XU Guidelines

**EFFECTIVE DATE:**08|15|2018
**POLICY LAST UPDATED:** 08|15|2018

## OVERVIEW

This payment policy documents the claim filing requirements when modifier 59, XE, XP, XS, or XU are used to indicate that a procedure or service was distinct or independent from other services performed on the same day. This policy is applicable to professional claims only.

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. 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. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

CMS has established the following four HCPCS modifiers (referred to collectively as – X {EPSU} modifiers to define specific subsets of modifier 59:

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

Beginning 8/15/18, BCBSRI will require providers to submit documentation for certain services when filed with one of these modifiers, as defined in the Policy Statement below.

## MEDICAL CRITERIA

Not applicable.

## PRIOR AUTHORIZATION

Not applicable.

## POLICY STATEMENT

**Blue CHiP for Medicare and Commercial Products**

BCBSRI follows CMS guidelines regarding NCCI PTP edits and the appropriate use of Modifier 59 or X {EPSU} modifier.

Effective August 15, 2018, the portion of the medical record that supports the separate and distinct procedure i.e., the location (different region), the procedural description (technique), and time, must be submitted at the time of claims submission for one of the following circumstances.

1. Modifier 59 or X {EPSU} is appended to <u>any</u> of the codes listed below OR

2. Modifier 59 or X {EPSU} is appended to a code not on the list below, but one of the codes below is also present on the claim.

**All claims submitted with Modifier 59 or X {EPSU}, appended to one of the codes set forth below, must be filed on paper with supporting documentation (e.g. operative/medical notes) for review. Claims filed electronically or claims filed without supporting documentation will be rejected/denied by our claims processing system. Rejected claims/denied claims must be re-filed as a paper claim along with supporting documentation.**

Process to file a paper claim:

1. Complete a CMS-1500 claim form
2. Submit the form and supporting documentation to:

Blue Cross & Blue Shield of Rhode Island
Claims Department
500 Exchange Street
Providence, RI 02903

To be considered for benefit payment, you must submit a clean claim within 180 days of the date of service or completion of an inpatient stay, or monthly in the case of an extended stay. Although not submitted for payment purposes, encounter claims must also be received within the same timeframe. Claims submitted after the time limit will be denied. Please remember that in accordance with your participating physician/provider agreement, you may not "balance bill" patients for services that were denied because you did not meet timely filing requirements.

The following is a list of codes in which documentation is needed for correct coding review one when of these codes and modifier 59 or X {EPSU} is submitted:

**Digestive System**

43239 Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple
45380 Colonoscopy, flexible; with biopsy, single or multiple

**Radiology**

70544 Magnetic resonance angiography, head; without contrast material(s)
76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

**Medicine/Ophthalmology**

92250 Fundus photography with interpretation and report

Any CPT code(s) denied upon review represent services denied based on NCCI PTP (Procedure to Procedure) edits and are administrative denials. Since these denials are based on incorrect coding and not medical necessity, these denials cannot be billed to the patient.

## COVERAGE

Not applicable.

## BACKGROUND

The NCCI PTP edits are comprised of edit pairs represented by a Column1/Column2 code. If a provider reports two codes of an edit pair for the same patient on the same date of service, the column 1 code is eligible for payment and the column 2 code is denied. If both codes represent a separate and distinct procedure or service, modifier 59 or X {EPSU} must be appended to the column 2 code to be eligible for payment. Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific X {EPSU} modifier when appropriate CMS

guidelines note that the –X {EPSU} modifiers are more selective versions of modifier 59 so it would be incorrect to include both modifiers on the same line.

The *CPT Manual* defines modifier 59 as follows:
"**Distinct Procedural Service:** 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/patient encounter
- procedure or surgery
- site or organ system
- separate incision/excision
- separate lesion
- separate injury (or area of injury in extensive injuries)

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."

One of the common misuses of modifier 59 is related to 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 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. Therefore, modifier 59 should not be appended simply due to the fact the codes represent different procedures/surgeries.

Below are examples of codes which should not be billed for the same patient on the same day, unless the codes represent a separate patient encounter, a separate lesion or different anatomical site.

Example - Gastroenterology: It is inappropriate to bill CPT code 43250 (Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps) **and** 43239 (Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple) as CPT 43250 is more extensive and would include any services performed under 43239.

Example - Gastroenterology: It is inappropriate to bill CPT code 45385 (Colonoscopy, flexible with removal of tumor(s), polyp(s), or other lesion(s) by snare technique), **and** CPT code 45380 (Colonoscopy, flexible; with biopsy, single or multiple) as CPT code 45385 is the more extensive code and would include any services performed under 45380.

Example – Radiology: It is inappropriate to bill CPT code 70553(Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences) **and** 70544 (Magnetic resonance angiography, head; without contrast material) as it is a misuse of CPT code 70544 to report it during the same encounter as 70553.

Example - Radiology: It is inappropriate to bill CPT code 20600 (Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance), unless otherwise listed; single lesion) **and** 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation). As per CPT coding manual instruction/guideline, it states to do not report 20600-20604 in conjunction with 76942.

Example - Ophthalmology: It is inappropriate to bill CPT 92134(Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina) **and** 92250 (Fundus photography with interpretation and report) as these codes represent mutually exclusive procedures which would not reasonably be performed at the same encounter.

## CODING
See policy statement

## RELATED POLICIES
Coding and Payment Guidelines

## PUBLISHED
Provider Update, June 2018

## REFERENCES:
1. Pub 100-20 One-Time Notification Transmittal 1422
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf
2. MLN Matters MM8863
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8863.pdf
3. Modifier 59 Article
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/