EDUCATIONAL SERIES: MODIFIER 59
(Better to use XE, XS, XP, XU)

Modifier 59 is the most widely used HCPCS modifier, it is defined for use in a wide variety of circumstances, and is often applied incorrectly to bypass National Correct Coding Initiative (NCCI) edits. This modifier is associated with considerable misuse and high levels of manual audit activity, leading to reviews, appeals, and even civil fraud and abuse cases. The introduction of four ‘X’ subset modifiers is designed to reduce improper use of modifier 59 and help to improve and speed up claims processing for providers.

The Current Procedural Terminology (CPT) Manual defines modifier 59 as a Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation & Management (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.

When using modifier 59, 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, the more appropriate modifier 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. 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 (only used on E/M 99201-99499 codes).

The Medicare NCCI includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/CPT codes should not be reported together either in all situations or in most situations. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are ‘separate and distinct’. 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. 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.

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.

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.

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.
Appropriate uses of modifier 59 include:

- Same patient, same day, same provider
- Different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.
- When the procedures are performed in different encounters on the same day.
- Two services described by timed codes provided during the same encounter only when they are performed sequentially.
- Diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.
- Used with the secondary, additional or lesser procedure of combinations listed in NCCI edits.
- There is NO other appropriate modifier.

NOTE: Two physicians in the same group, with the same specialty, performing services for the same patient on the same day, are considered by Medicare to be the same physician

Inappropriate uses of modifier 59 include:

- When the basis for its use is that the narrative description of the two codes is different.
- Different diagnoses are not adequate criteria for use of modifier 59
- Code combination not appearing in the NCCI edits
- Submission of E/M Codes
- Submission of weekly radiation therapy management codes (CPT 77427)
- The NCCI tables lists the procedure code pair with a modifier indicator of "0"
- Documentation does not support the separate and distinct status
- Exact same procedure code performed twice on the same day
- Multiple administration of injections of the same drug
- If a valid modifier exists to identify the services

XE, XS, XP, XU Modifiers: (**See Examples of appropriate use, last page of this News Blast**)

In January 2015, CMS developed modifiers XE, XS, XP, and XU to provide greater reporting specificity in situations and may be utilized in lieu of modifier 59 whenever possible. Although CMS does not require use of these ‘X’ modifiers the providers should use in place of 59 as the ‘X’ modifiers bypass the Medical Review Edits associated with modifier 59 which slow down the claims processing.

- XE – Separate encounter, A service that is distinct because it occurred during a separate encounter
  This modifier should only be used to describe separate encounters on the same date of service.
- 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 ‘X’ modifiers define specific subsets of modifier 59 and offer more selective scenarios than modifier 59 so it would be incorrect to include both ‘X’ and 59 modifiers on the same service line.

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.

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.

Per CR8863, CMS will not stop recognizing the 59 modifier but notes that CPT instructions state that the 59 modifier should not be used when a more descriptive modifier is available. CMS may selectively require a more specific X{EPSU} modifier for billing certain codes at high risk for incorrect billing. 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{PSU} modifiers.

Per SE1503, CMS advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier 59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015.
MODIFIER 59

Resources:
Medicare Learning Network (MLN) Matters® Number SE1418 – ‘Proper Use of Modifier 59’:

Medicare Learning Network (MLN) Matters® Number MM8863 – ‘Specific Modifier for Distinct Procedural Services’:

Medicare Learning Network (MLN) Matters® Number SE1503 – ‘Continued use of Modifier 59’:

National Correct Coding Initiative Policy Manual for Medicare Services:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html


WPS Face Sheet: https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/modifier-59/


Moda Health, Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service, RPM027:
https://www.modahealth.com/pdfs/reimburse/RPM027.pdf

Contact Software Support for assistance or any questions via:
From MEDPM or MEDEHR Sign On screens, double click on ‘support@medtronsoftware.com’ to compose an email to the Software Support Dept.

-OR-
  Phone: (985) 234-0599 (local)
          (800) 978-0599 (toll free)

-OR-
  Fax: (985) 234-0609
Examples of appropriate use of modifiers XE, XP, XS, XU, or 59: (Source: ModaHeath)

<table>
<thead>
<tr>
<th>Example</th>
<th>Modifier to use:</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>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).</td>
<td>XE</td>
<td>Separate encounter.</td>
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<tr>
<td><strong>Modifier XP is a little unclear. Once possible scenario might be:</strong></td>
<td>XP</td>
<td>• May be the same encounter.</td>
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<td>The patient is seen in the office by a family practice physician, who in the course of the visit encounters a problem outside their scope of ability so calls in (or arranges an immediate transfer to) a specialist physician at the same claim to perform the needed service.</td>
<td>XP</td>
<td>• Is definitely the same clinic/TIN.</td>
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<tr>
<td>Injection into tendon sheath, right ankle (20550) and injection into tendon sheath, left ankle (20550-XS).</td>
<td>XS</td>
<td>• Same encounter</td>
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<td></td>
<td></td>
<td>• Different anatomical site and contralateral structure.</td>
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<td></td>
<td></td>
<td>• (Note: 20550 is not eligible for modifiers LT or RT.)</td>
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<tr>
<td>Separate injury (or area of injury in extensive injuries).</td>
<td>XS versus 59</td>
<td>Depending upon your specific circumstances XS or 59 may be most appropriate.</td>
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<td>A right cardiac cauterization (93451) was performed. Based on the findings, a medically necessary cardiac value repair (33418) was required. The NCCI edits reveal a “1” indicator. What modifier should be reported on the code combination? What is the proper billing?</td>
<td>XU</td>
<td>Depending upon your specific circumstances XU or 59 may be most appropriate.</td>
</tr>
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<td>A diagnostic procedure is performed. Due to the findings, a decision is then made to perform a therapeutic/surgical procedure. (This may or may not occur in the same procedure room during the same session/encounter.) For example, diagnostic cardiac angiography leads to therapeutic angioplasty. See CCI Policy Manual, chapter 1, modifier 59 guidelines. (CMS 3)</td>
<td>XU versus 59</td>
<td>Depending upon your specific circumstances XU or 59 may be most appropriate.</td>
</tr>
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<td>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).</td>
<td>59</td>
<td>• Same encounter</td>
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<td></td>
<td></td>
<td>• Same organ system and/or structure (skin)</td>
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<td>• Different lesions.</td>
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<tr>
<td>Diagnostic mediastinoscopy via midline incision (39400) and thoracoscopy of right lateral lung via lateral incision with biopsy of pleura (32609-XS??). Different organ system (e.g. laparoscopy on separate organ systems).</td>
<td>59</td>
<td>• Same encounter</td>
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<td>• Same organ system (respiratory)</td>
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<td>• Different incision.</td>
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