PCG SOFTWARE

A Primer on the Coding Modifier 59 Subset: XE, XP, XS and XU

by Andria Jacobs, RN, MS, CEN, CPHQ

Intro

The Centers for Medicare & Medicaid Services (CMS) established four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of modifier 59, which is used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances.

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

- XE – Separate Encounter
- XP – Separate Practitioner
- XS – Separate Structure
- XU – Unusual Non-Overlapping Service

Modifier XE

The "key" element in Modifier XE's ability to override the application of a CCI edit is time. The acceptance and payment of the normally denied code in the edit rests on the provider's successful demonstration that, in this case , the two services in the edit-pair were non-associated separate encounters performed at different times and none of those services overlapped or comingled. "This" was done at Time[1] whereas "This" (or "That") was done at Time[2]. The utility of XE as an edit override modifier is, however, conditional. Certain inherent features of a sub-set of codes within the CPT -4 (other coding guidance in that publication related to specific CPT codes and a specific CMS's rule for using the modifier XE) may limit its application.

Time Span Codes

The starting point for understanding modifier XE is to recognize that a number of CPT and certain HCPCS codes are "Timed Codes." They have a "time" related component built into their descriptor. These time limits are explicit and are expressed in standard time units (e.g., minutes, hours, days, and months) that apply to the delivery of the code's services. Many physical therapy "modality based" codes such as 90736, "Hydrotherapy each 15 minutes" incorporates a time interval in its definition. CPT-4 Coding Guidelines may also establish a time interval outside of a code's formal descriptor. For example, CPT coding guidance for 95250, "Ambulatory continuous glucose monitoring" dictates that it should not be reported more than once per month. CMS instructions for a specific code in at least one instance explicitly state that it is not appropriate to bill that Modifier XE with a code. That code is CPT 77427, "Weekly radiation therapy management."

1."External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional"
2. That is, of course, just a short-hand way of saying that it must come first

The “Time” in time span codes can also be expressed indirectly as is the case with codes where “per session” or “per encounter” is wrapped up in the descriptor. Finally, there are so called “once-in-a- lifetime” codes where the nature of the clinical service dictates that the procedures can be performed only once. For example, code 44950 “Appendectomy.”

The applicability of modifier XE when a time span code is incorporated into a CCI Edit requires special mention. If the codes in the Edit are clearly time distinct procedures and they lack any overlap in their clinical content, the Modifier XE is applicable. However, if the content of the two services in the Edit are associated in any way, such as a sequentially staged procedure, the modifier XE generally cannot be used to override a denial of one of the Edits service based on separate encounters delivered at different times. The following two examples are illustrative.

When reported together by the same provider on the same day of service, the CCI Edit pairing code 97306, ”Hydrotherapy”; each 15 minutes” with code 97112 “Neuromuscular re-education; each 15 minutes”, denies code 97306 to the more inclusive code 97112. However, this specific edit allows a modifier override. Therefore, when these two services are delivered at different time intervals, they can, by placing modifier XE on the otherwise denied code (e.g., 97306), negate the edit and allow the payment of both codes.

Contrast this with the reporting of Modifier XE within the “family” of time span codes that comprising ECG record reviews. These are codes; 93268 “Ecg record/review”, code 93270 “Remote 30 ecg rev/report”, code 93271 “ecg/monitoring and analysis” and, code 93272, “ecg/review interpret only.” A review of the long-form definition of code 93268[1] none of the three other codes, 93270, 93271 and 93271, would be separately reimbursed if reported in conjunction with it. Here, both a 30-day time interval applicable to both the main code and its components, combined with the fact that each share the common elements found in the main code (93268), would preclude the use of Modifier XE from being used to obtain a separate payment.

A code not explicitly containing a "Time Span" in its descriptor may also acquire a degree of temporality by way of a payment policy. One of the more familiar examples is the auxiliary services codes that are incorporated into the global surgical package. That package effectively bundles certain evaluation and management services affiliated with the surgery into the single package payment. The payment amount assumes that within the package time frame (for example, ninety days), a set number of these non-surgical management services were performed in that fixed amount of time. The veracity of this assumption (i.e., that providers do typically deliver these services in the quantities assumed) has been recently challenged based on research. That, in turn, has thrown the doubt on the global package concept.

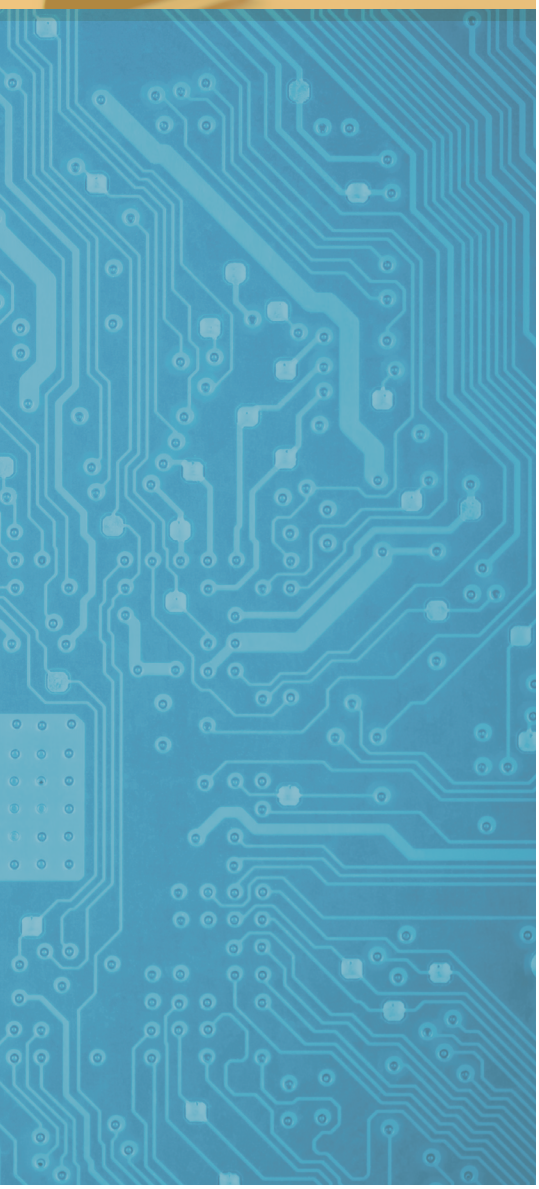
The important point relative to XE and time span codes is that when a time interval appears in a code a presumptive edit override, justified based on XE, is typically not recognized when submitted by the same provider or group.

Service Type and Service Time

For CMS at least, whether or not the individual procedures in a CCI Edit Pair can be overridden through the use of XE's exception based on separate encounters at separate times also depends on the "service type" of the codex in the edit pair. The dichotomy here is between "diagnostic" and "therapeutic" services. When one of the two reported procedures in the edit is a surgical or non-surgical therapeutic procedure and the second procedure is a diagnostic procedure a special and somewhat complex CMS rule may infringe on the provider's ability to use Modifier XE to negate the Edit.

The rule states that, given such a mix of service types in the Edit, the fact that the services were delivered at separate times, thus separate encounters, is a necessary condition but not a sufficient condition to insure the recognition of XE as a device that can be used for bypassing the edit. Something more is required. That something more is the additional requirement that relates to the sequential order between the diagnostic procedure and the therapeutic procedure that was delivered.

More specifically, the rule states that when a diagnostic procedure and therapeutic procedure appear in a CCI Edit Modifier XE is used correctly if, and only if, (1) the diagnostic procedure constitutes the "decisional basis" for the therapeutic procedure[2], (2) the two services did not comingle in content or overlap in delivery, or (3) the diagnostic test was not an inherent or required part of the therapeutic procedure.



Additionally, when performed after a surgical or non-surgical therapeutic procedure or service, further conditions are added. The diagnostic test or procedure is permissible only if it was (1) done at a different (e.g., a later) time, (2) the diagnostic test was not a part of the therapeutic procedure that preceded it, or (3) the two services did not comingle and the diagnostic procedure was not a part of the therapeutic procedure's routine follow-up care.

As with all of the –X{EPSU} modifiers, modifier XE is to be used only as a modifier of last resort. Other modifiers which may be time related are Modifiers; 78 "Unplanned Return to the Operating/Procedure Room", Modifier 79 "Unplanned Procedure or Service by the Same Physician in the Post Operative Period", or Modifier 91, "Repeat Clinical Laboratory Test". All three of those modifiers are eligible, used appropriately, can also negate a CCI Edit.

Recapping Modifier XE

Whether a "separate" service encounter did or did not occur, the core concept in Modifier XE is the most transparent of the four -X{EPSU} modifiers. Aside from the "fuzziness" of certain aspects of CMS's diagnostic procedure/therapeutic procedure "special rule," and the work-a-day chronic operational problems that payers have always faced in managing duplicate claims submissions, determining separate service encounters is generally straightforward. It is the least controversial component of the re-casted Modifier 59.

Modifier XP

XP is the "separate practitioner" modifier. Its use attests that the service(s), a portion of the service(s,) a different stage of the service(s), or a reoccurrence of the initial service is distinct because a different provider or providers have participated in one or more portions of the service delivery. This could have occurred at the same time (e.g., the same day or encounter) or at different times (e.g., on different days at different encounters) and can involve the same procedure or different procedures. The key issue is that at *least two* identifiable providers/ practitioners were involved in the service delivery.

In the context of CCI Edits, in the simplest case, the determination of whether a provider correctly reported Modifier XP and successfully negated the operation of an edit is, in principle, not difficult to ascertain. Do both of the providers follow eligibility rules based on the types of services that were delivered? What is the provider's specialty status? What about the provider or practitioner's status relative to his /or her group affiliation? Typically, Medicare considers two physicians in the same group with the same specialty performing services on the same day as the *same provider*. Were these requirements met?

Other "Separate Provider" Modifiers

There are a number of modifiers other than XP that incorporate the performance of services by different providers. The Co-surgery Modifier 62, the Team Surgery Modifier 66 and the Assistant Surgery Modifiers 80, 81 and 82 immediately come to mind. Next there are the modifiers for the pre, intra and post operative period, Modifiers 54, 55, and 56. Then there is Modifier 58 for staged procedures, and Modifier 77 for a repeat procedures by another physician or practitioner. Each of these, directly or indirectly, incorporates the likelihood or the possibility of one or more other providers being part of the service delivery process. However, across this list, only Modifier 58 is eligible to trigger an override of a CCI Edit.

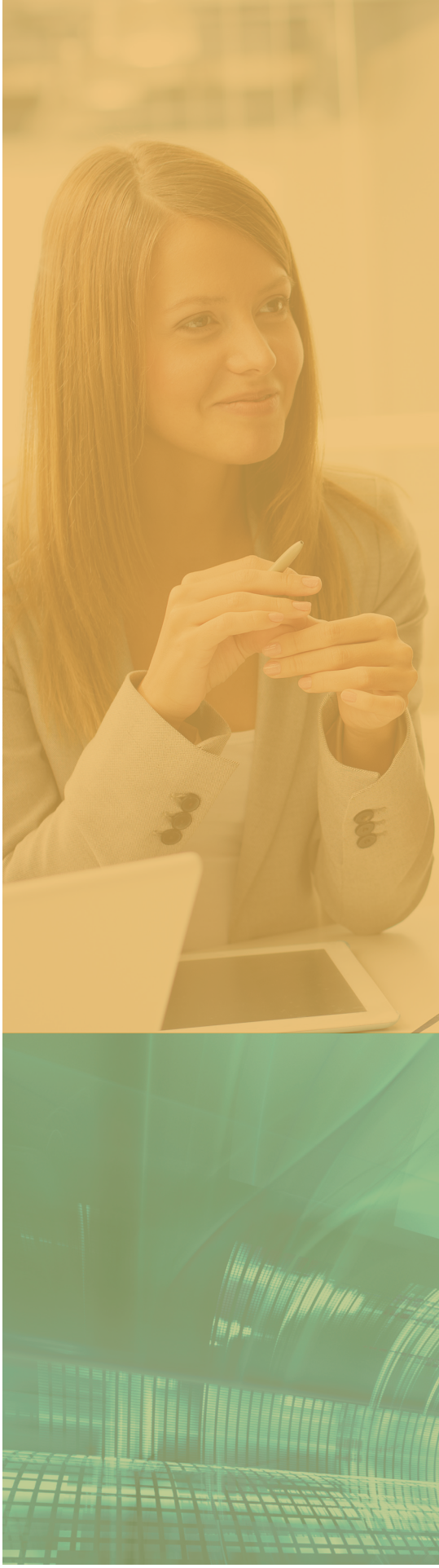
The Practical Side

The unexceptional functionality of Modifier XP in principle is not necessarily true in practice. It is in the execution or application where problems arise for XP. Increasingly, physicians/practitioners deliver services in (or through) ever more complex organizational structures. These entities operate under contractual arrangements whose legal, management, financial and clinical structures can take on a bewildering array of forms and functions. This makes it difficult to assess what kind of "separateness" payers should require between two or more ostensibly "distinct" providers. When providers working in a shared clinical and financial arrangement such as a medical group seek to avoid a CCI Edit using XP by having different providers in the group parcel the two services, Modifier XS is undermined. That use of XP, from a reimbursement perspective, then becomes abusive if not fraudulent.

For professional services delivered in an in-patient or hospital outpatient settings, identifying "separate "providers through the use of Modifiers TC and 26 has been the standard tools since the inception of CPT. For example, those modifiers have allowed payers to discern the correct allocation of reimbursement for contract based hospital specialists like radiologists and pathologists. However, the emergence of groups employed by facilities such as hospitalists, intensivists, and, now, laborists introduces new issues of who are the separate providers and what entity or entities is he/she separate from (e.g., the facility, a facility owned third party entity, another third-party).

Modifier XP- The "Wild Card"

As CMS apparently (or eventually) moves forward with its original stated intention of linking the four –X {EPSU} modifiers with selective groups of new or existing CCI Edits, the inherent weaknesses in the current definition of the separate provider Modifier XP are likely to surface. Separate provider may indeed be the "wild card" in this new quartet of modifiers. It is likely that more complex definitions and rules for defining and sorting out provider separateness will be a part of CMS's and other payer's reassessments.



Modifier XS

The X- {EPSU} modifier "XS", correctly used, allows providers to override a CCI edit based on its "situs" (e.g., its place, location, or locus).[1] It designates that the situses or locations of two similar or otherwise inclusive procedures were distinct. The procedures were done "here" and "there" and not just "here." At locations P^x and P^y and not at P^{xy} or P^{yx} and that an anatomically defined site based distinctiveness was present between them when performed on the same day or at the same encounter. Both services are deemed separately payable because of these different physical locations.

Identifying and distinguishing between "concrete" locations appear, at first glance, to be relatively simple. Anatomy, the study of the structure of the body, and physiology which catalogues those structure's functions, provide a well established body of knowledge for doing so. This knowledge underlies and defines the "stuff" of medical and surgical practice. It is readily available for sorting out the "here" from the "there". The anatomical classification of the human body based on organ systems is an example.

In addition to body structure classification based on organ system, a significant amount of other location terminology stands ready for use including body region, body area, and anatomical site. There are also associated concepts such as "contiguity" (contiguous structures) and "laterality" (contra-lateral structures such as iliac crests). These are available for developing rules to apply when determining whether two services should be considered as distinct based on the anatomical situses where the services were performed.

1. See: Medical Dictionary for the Health Professions and Nursing © Farlex, 2012.

Within Medicare's Correct Coding Initiative, Modifier XS is now the vehicle for overriding a CCI Edit when evidence is presented that the otherwise denied service in the edit was delivered at an anatomically different locale.[2] This functionality is operative, however, only in context of a specific CCI Edit that allows a modifier override and meets the anatomical site based rules developed by CMS. It should be noted that CMS states that an incorrectly reported modifier override, based on alleged different anatomical sites, historically have been frequently misused based on the experiences with XS's predecessor Modifier 59.[3]

What are those rules? Let's first examine the recently announced X-{EPSU} modifier rules specific to modifier XS; then we will examine CMS rules that applied to CCI Edit overrides based on anatomical site under the legacy Modifier 59.

Current CMS's Guidance for Modifier XS

CMS's X- {EPSU} modifiers were introduced almost one year ago. They have been officially operational since January, 2015. However, guidance for the correct use of each of these modifiers has been minimal. The guidance that has, to date, been released has consisted of a list of "do's" and "don'ts" published on the websites of local Medicare Carriers.

For modifier XS, the content of its guidelines is sparse. Providers are advised that they must supply documentation that indicates the services were provided on different organs or structures and are given a simple example.[4] they also remind us that modifier XS like, all of the other X- {EPSU} modifiers, are only to be used when no other applicable modifier is available. This is of particular importance for modifier XS due to the number of other anatomical based modifiers (e.g., the "T" and "F" modifiers), that preempt XS's reporting. More about those other modifiers and XS later.

2. Technically the legacy Modifier 59 many also used. For this discussion we shall ignore that temporary allowance.
3. See Medicare Learning Matters, Publication MM8863, dated 8/15/14 CMS Change Request 8863 Transmittal 1422, 8/14/14.
4. CMS says modifier XS would be inappropriate "if both procedures were done on the liver in a single encounter."

The remaining CMS guidance focuses on procedural rules that are applicable to all modifiers. For example (1) Modifier XS must be placed on the Column 2 (i.e., the denied code) in the edit-pair, and (2) the generalized rule that the use of XS is restricted only to submitted code pairs which together constitute currently active CCI edit.

CMS Guidance for Reporting Different Anatomical Site under Modifier 59

Prior to the introduction of X-{EPSU}, CMS's 59 modifier policies emphasized the need for providers to clearly identify the specific anatomical site(s) when reporting alleged "distinct procedures". CMS provided a significant amount of guidance, and examples, relative to what was or was not acceptable when specifying procedures performed at different kinds of anatomical sites. Some of the guidance outlined general conditions for the modifier's use; other guidance was much more rule oriented, detailed and, therefore, utilitarian.

The *general requirements* applied to all four components of Modifier 59 (e.g., separate encounters, separate practitioners, separate sites and separate services). They can be summarized as follows:

- The most common uses of the Modifier 59 is for surgical procedures, non-surgical therapeutic procedures, and diagnostic procedures
- Modifiers are intended to communicate specific information about a certain service or procedure that *is not already* contained in the code definition itself
- Modifier 59 is only to be used to identify clearly *independent services* that represent significant departures from the usual situations described by an NCCI edit
- Modifier 59 should only be used if *no other modifier* more appropriately describes the relationships of the two or more procedure codes

The specific rules applicable to Modifier 59 for allowing separate procedures based on different sites were summarized as follows:

> "Modifier 59 is used appropriately for 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."[5]

As the services described in edit-pair codes are performed across a range of "anatomical site types", CMS developed a series of detail level rules. These attempted to establish "situses type conditions" that would qualify a procedure as "distinct services". This "drill down" guidance is summarized in the following chart.

Modifier 59 Guidance for CCI Edit Overrides Based on Distinctive Anatomical Site Types*

If the:	Then:	Action:
Procedure was performed on different body organs	They are Separate Procedures	Allow a modifier edit-pair over-ride
Procedure was performed on the same body organ	They are not Separate Procedures	Do Not Allow a modifier edit-pair over-ride
Procedure was performed on different lesions of the same body organ	They are Separate Procedures	Allow a modifier edit-pair over-ride
Procedure was performed on the same lesion of the same organ	They are not Separate Procedures	Do Not Allow a modifier edit-pair over-ride
Treatment site was a contiguous anatomical structure of the same organ	They are not Separate Procedures	Do Not Allow a modifier edit-pair over-ride
Treatment site was of non-contiguous anatomical structure of the same organ	They are Separate Procedures	Allow a modifier edit-pair over-ride
Procedure was performed on different lesions of the same organ at contiguous anatomical site or region/area	They are not Separate Procedures	Do Not Allow a modifier edit-pair over-ride
Procedure performed on different lesions of the same organ at a non-contiguous anatomical sites or region/area	They are Separate Procedures	Allow a modifier edit-pair over-ride
Procedure performed on non-contiguous lesions of the same organ at a different anatomical site or region/area	They are Separate Procedures	Allow a modifier edit-pair over-ride
Procedure performed of contiguous lesions in the same organ at the same anatomical site or region/area	They are not Separate Procedures	Do Not Allow a modifier edit-pair over-ride
Procedures performed of different areas of injury in cases of extensive injuries (e.g., multiple traumatic injuries)	They are Separate Procedures	Allow a modifier edit-pair over-ride

5. Derived from CMS. National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § E, "Modifiers and Modifier Indicators." See also, CMS MLM"proper Use of the Modifier 59", SE1418, Revised June 2, 2014.

Modifier XS's and HCPCS's Modifiers

Within the framework of the Correct Coding Initiative, all X- {EPSU} modifiers are considered to be "modifiers of last resort". They are only available for use by providers if no other more appropriate modifier that better describes the situation is available to use. This rule applies to X- {EPSU} in the same fashion as it applied their predecessor Modifier 59.

For the "XS" modifier this has special implications. This is due to the presence of twenty-eight specific anatomical based modifiers in the HCPCS coding system. They too are available to modify the service or procedure so as to clarify the clinical situation and make the location of the service explicit. They are the anatomic NCCI-associated modifiers RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. Used appropriately each is available to indicate that a typically denied service in a CCI Edit service was performed at a different anatomical location and, therefore, should be eligible for separate reimbursement. For example, modifiers TA -T9 and not XS are used here when separate toes are the site of procedures in clarifying the clinical situation.

As an illustration, consider code 11620, "Excision of malignant lesion" when reported with code 17270,"Destruction, malignant lesion," both performed on the same day of service. These codes, reported together, trigger the CCI Edit 17270/11620. In it code 11620 is denied as included in code 17270. However, using an existing HCPCS anatomic modifier to identify the separate sites, that edit can be negated. For example, placing modifier -TA, "left foot, great toe" on code 11620 and adding modifier -F3 "Left hand, fourth digit" on code 17270. The different sites are now explicitly identified and the normally denied code 11620-TA becomes reportable and payable.

Despite the availability of these HCPCS anatomical modifiers and the CMS's requirement that they must be used as the modifier of "first resort", their utility is limited. Most apply to specific anatomical appendages (e.g., fingers or toes) or to the arteries of the heart.

The remaining ones have the opposite problem in that they are very general. For example, RT- “Right Side” and LT- “Left Side”. This restricts their application to body structures (e.g., arms, shoulders, etc.). The broad based laterality expressed by -RT and- LT is also not easily adaptable to internal body systems, when defined by organs, tissues, areas, or structures. As an illustration procedural codes for surgery of the abdomen have no distinctive anatomic modifiers. A modifier to identify a surgical procedure on the “upper right quadrant of the abdomen” does not exist. This is the case for the majority of surgical procedures, non-surgical therapeutic procedures, and diagnostic procedures. CMS only permits these modifiers to be used with specific the code ranges and code types. Moreover, industry practice beyond Medicare may not recognize these modifiers or use them in selective ways.

CPT Codes and the Designation of Anatomical Site

The services defined in many CPT codes reference in some way an anatomical area. The organization of CPT-4 reflects this. Codes in CPT, for the most part, are grouped based on type-of-services (e.g., codes in the range of 20000-29999 reference the ”Musculoskeletal System”, etc). In some cases at least these broad types of services are further grouped in sub-sections that are *anatomically* based (e.g., the neck, the thorax, the spine, the shoulder, the forearm, the wrist, etc.). Additionally, many individual CPT codes may contain, in their definitions, anatomical location terms that designate locus concepts such as laterality.

As such, one might foresee the fabrication of code level anatomical site decision rules (e.g., “separateness rules”) built around the organization of CPT that could potentially be used in applying site specificity. Indeed the organizational structure of the many edits in the Correct Coding Initiative, not unexpectedly, is grouped by anatomical site. However, the amount of effort required to establish these rules and the practical problems of clearly assigning codes to these groups and sub-groups systems in a mutually exclusive and exhaustive manner is, at best, difficult to envision.

Boundary Problems and Levels of Anatomical Site Specification

Establishing anatomical site distinctiveness is a question of setting boundaries. Two or more services are considered to be “distinct” and perhaps separately payable because each was performed at a *different* physical location.

Anatomy establishes the general parameters that allow everyone to distinguish between what is “here” and what is “there” so that no one disputes situs issues arising between what is the foot and what is the head. However, at lower and more complex levels of analysis, drawing anatomical and physiological “red lines” is not as settled. Not surprisingly, governmental or non-governmental payers, with a nod from various providers and their representatives, negotiate the boundary rules. At the margins, so to speak, they define the anatomical and physiological “red lines”. In this process providers and their professional representatives, not unexpectedly, adopt different policy positions.

Expressed at the technical code level, providers favor fragmenting or unbundling anatomical structures into ever more articulated sites. Payers, such as CMS, generally take the opposite position and write rules to bundle the codes applicable to anatomical sub-structures so that their definitional scope becomes more comprehensive and more inclusive.

The physiological functioning of body systems also serves to complicate the differences between anatomical structures, for example, the concept of contiguous verses non-contiguous applied to anatomical structures. How non-contiguous must two anatomical structures be to negate their status as distinct sites? For example, Medicare's decision that procedures performed on the posterior segment structures in the ipsilateral eye constitute the treatment of a single anatomic site. That decision, expressed as a CCI edit, denies code 67220 to code 67210.[6] However, a retinal surgeon may disagree and point out that those two sub-structures of the posterior of the eye at issue here, the choroid and the retina perform distinct physiological functions and this physiological fact should "trump " the fact that they are adjacent to one another.

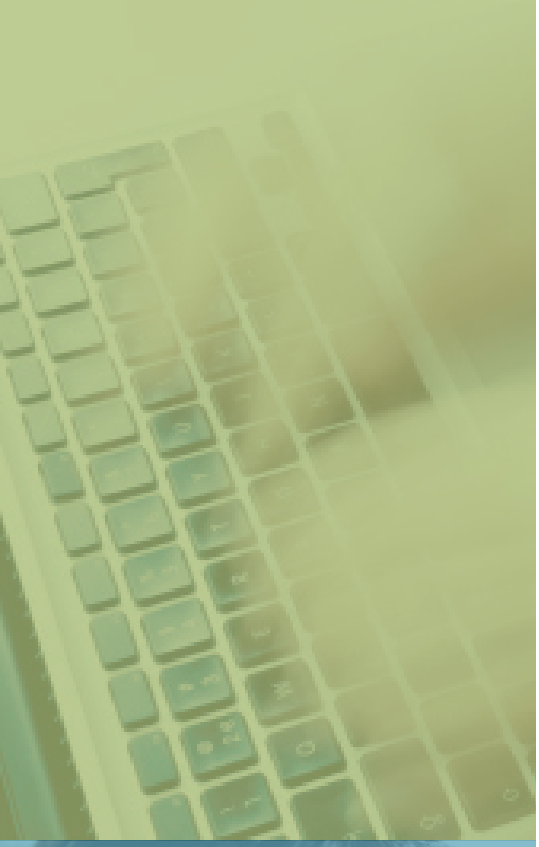
Finally, in some cases the distinction between "the here" and "the there" breaks down. For example, the work of the interventional cardiologist frequently encounters various types of lesions; interior lesions, exterior lesions and bifurcated lesions. For these, the bright lines in anatomical structure between two lesions tend to break down depending on the lesion type.

Site Overlap and Service Overlap

In use, two of the X-{EPSU} modifiers, XS and XU may overlap when sorting out different procedures and different sites.

For XS the *refusal to recognize* that modifier when it is placed on the second service when the services delivered at the same site looks like this. Delivered at Organ^{A}, the payment for the performance of a procedure P^{x1} whose services were P^{x1s1} through services P^{xs10} accounts for all of the service on that day of service. Therefore, P^{x} at location Organ^{A} should be paid only once. An additional payment for an additional similar procedure at Organ^{A} (let's call it P^{x2}), whose service components were also P^{x2s1} through P^{x2s10}, are duplicative. The denial is based on site overlap.

However, in a different situation where procedure P^{x1}, at location Organ^{A} was performed in conjunction with a second procedure P^{y} whose services call them P^{yS4} through P^{yS7} are the equivalent of the subset of P^{x1}, (for example in Px^{S4} through P^{xS7}) the site modifier XS is not applicable to the edit. The appropriate modifier that should be reported with the second service code would be modifier XU and the services are distinct. P^{y} would, of course, be denied and the basis for the denial would be based on the service overlap between the two procedures. Steps P^{xs1} through P^{xs10} are inclusive of steps P^{XS4}. The denial is based on *service overlap*.



Modifier XS More Clarity or Continued Confusion

The question is has the introduction of Modifier XS clarified anything? Are the rules for exercising the modifier driven edit exception process in the Correct Coding initiative any clearer? Are providers any better able to understand and use this edit over-rider modifier. Should we now expect a decrease in the CMS reported provider misuse based (incorrectly) on site that was characteristic of Modifier 59 s history where providers frequently attempted to negate CCI edits but failed to correctly interpret what are distinct anatomical sites?

To begin, it is important to understand that CMS's fragmentation of Modifier 59 into the four X-{ESPU} modifiers for the most part has maintained the legacy modifier's descriptions. To date, very little new has been added. Therefore, the "whole" that was Modifier 59 remains is essentially replicated across in X-{ESPU} in the sum its parts. Having not changed the content of the definition of the modifier 59 and the failure by CMS to introduce and any new detail level anatomical situs rules providers must fall back on the legacy rules and examples that, over the years, CMS has developed for Modifier 59.

Simply put, it does not appear that rule clarification was the intent of when the four X-{EPSSPU} modifiers were introduced. The intent of when the four X-{EPSU} modifiers were introduced. This year's appearance of modifier XS and , for that matter, the three other X-{EPSU} modifiers, seems to have marked the initiation point, the start of a data collection process so that CMS could gain additional raw material from providers to develop additional more precisely targeted CCI edits. It appears to be based on the assumption that requiring providers to report the modifier XS when they request an edit override based on Situs differences will, going forward, allow CMS to more economically "sort out" frequently reported code combinations where separate situs is alleged. From that data the agency can then fabricate, or refine existing, situs rules to improve their adjudication of this type of edit overrides. Whether end point of that process will further rationalize, and thus clarify, what are or are not distinctive anatomic sites remains to be seen.

Modifier XU

On January 1 2015 the Center for Medicare and Medicaid Service's new policy for the use of Modifier 59 ("Distinct Procedural Service") became effective.[1] Since its announcement, the policy has attracted a great deal of attention. The significance of this policy change, however, remains unclear. Does this change merely represent a repackaging of Modifier 59 or does it provide a more workable framework for managing this controversial modifier?

Often characterized as "the modifier to use to bypass National Correct Coding Initiative edits," the inappropriate use of modifier 59 by providers has long been recognized by CMS and private payers.[2] Abuse of the modifier materially contributes to Medicare's total incorrect payments.[3] It is the most frequently used modifier to override CCI Edits and is reported in about one out of five claims. In attempting to control the use of this modifier use Medicare Carriers now conduct periodic manual audits of it. Those audits have led to case reviews, provider appeals and, the initiation of CMS fraud and abuse actions.

The *first component* of the new policy consists of two basic components: (1) The fragmentation of the legacy 59 Modifier into four new "- X {EPSU} modifiers, and (2) The *proposed* development of set of CCI edits which can only be by-passed by the exclusive use of a designated new modifier. To date, a timetable for implementing the second component has not been announced.

1. Modifiers XE, XS, XP, and XU are effective as of January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015.
2. See Use of Modifier 59 to By Pass Medicare National Correct Coding Edits Report, Office of Inspector General Report OEI-03-02-00771 November, 2005.
3. HHS Office of Inspector General, Compendium of Unimplemented Recommendations I 2012, Page 30.

Based on Medicare's claims experience with edit override modifiers the most frequent pattern of misuse was the submission of claims where the provider, using Modifier 59, incorrectly reports that the services in Column 2 of the edit does not overlap with the services in the edit's Column 1 code. That, in turn, allowed the separate reporting of what was an overlapping and/or duplicative service(s). CMS notes that such actions prevent CCI edits from performing the very task they were designed to do.[4]

The objective of this article is to focus on the modifier XU in the new- X {EPSU} modifier set. Going forward that modifier is the vehicle for overriding a CCI edit based on the argument that the services in the edit were unrelated and non-overlapping.

Contrasting Definitions of Modifiers 59 and Modifier XU

One important result of CMS's "unpacking" of Modifier 59 was to change a key part of that modifier's definition. Modifier 59's CPT Codebook legacy definition was grounded on the key operative terms "separate and distinct". When those conditions were met the separate reporting of a procedures and services that, under normal circumstances, was not reportable together could be separately reported. As applied to the codes in a CCI edit pair, the litmus test for a Modifier 59 override was are there any services in the edit's two codes that both 'stand out' and are unrelated?

Modifier XU, in contrast, as defined by CMS, reads; "The Use of a Service That Is Distinct Because It Does Not Overlap with the Usual Components of The Main Service." Now the two procedures in a CCI edit are "separate and distinct" only if the services in the Column 2 code do not overlap with the usual components of the edit's "main service." This is based on the content of both of the codes in the edit. But how does one determine when such conditions are in place? CMS has recently published some guidance for the use of the Modifier XU.

4. The second most frequent pattern of misuse of Modifier 59 was providers incorrectly reporting that some of the services performed were located at a distinctively different anatomical site. A companion article on the X {EPSU} modifier, modifier "XS" ("A Service That Is Distinct Because It Was Performed on a Separate Organ/Structure") will be discussed in a subsequent issue. The definitions, hence the decision rules, for applying the two remaining X {EPSU} modifiers -XP and –XE are more straightforward. The use of those modifiers is based on either different times or different providers.

CMS's Modifier XU Guidance

CMS's principal guidance for the correct use of the XU modifier is a list of "do's" and "don'ts" published on the websites of its network of local Carriers. The appropriate actions listed for using XU (e.g., the "do's") turn out to be a re-statement of the rules for correct use of Modifier 59! For example, "The services in question must make up a code pair in a valid CCI edit." "The XU modifier must be placed on the (otherwise denied) Column 2 code." "Modifier XU should not be used if a more appropriate modifier exists." "The provider must supply documentation that the denied service was not part of the main service". The guidelines for the inappropriate use of modifiers XU adds little more. Most of the "don'ts" are mirror images of what was listed as appropriate. For example, "do not use modifier XU if the service codes do not make up a valid CCI Edit Pair."

To summarize, in this guidance, there is, unfortunately, no mention of how to operationally determine the presence or absence of overlapping services when an override modifier appears in a CCI Edit.

Given these shortcomings of the new guidance for XU, should we look backward? Can anything useful be gathered from CMS's guidance prior to the introduction of the modifier? More specifically, does any of the earlier guidance for appropriately using CCI edit over-rides based on Modifier 59's rules for "separate and distinct" procedures clarify the new requirement that there be "no overlap of the main service"? Those are the criteria that are now essential for the appropriate use of modifier XU.[5]

5. CMS also has established special rules for the appropriate Modifier 59 use when a diagnostic procedure and a therapeutic procedure appear in a CCI Edit. See CMS Website Correct Coding Initiative, Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service – Updated 03/24/15.

Separate Services Based on the Code Descriptors in the Edit

CMS has frequently reminded providers in various Correct Coding Initiative educational and regulatory publications that differences in the narrative descriptions of the two codes in a CCI edit, when reporting procedures at the same anatomical site for the same service encounter, *do not constitute a sufficient condition* for the use of that modifier. CMS states that there are *always* some similarities and some differences in the code descriptors in a CCI Edit. If there was no difference, the codes would be duplicates. If there was no relationship between the services, there would be no basis for the edit.

Nevertheless, it is important to point out that while is it not a sufficient condition, the presence of both the similarities and the differences in a CCI edit's code descriptors, when taken together, are necessary conditions. This applies to both the establishment of the edit and the ability of a modifier to over-ride it. Why is this so? First, without any differences between the two codes the edit would negate itself. Second, if there are no similarities the two codes would be unrelated and there would be no rationale for editing them. Finally, the designation of modifiers such as 59, or now XU, which enables the "modification" of the CCI edits' bundling and denial processes would themselves make no sense.

Code Descriptors, CCI Edits, and Edit Override Modifiers: An Example

As an illustration of CMS's position on differences in code descriptors in CCI Edits justifying edit overrides and modifier use, consider the CCI edit 34833/34820. The Column 1's comprehensive code 34833's description reads "Open iliac exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral." The Column 2 component code 34820's reads "Open iliac exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral."

In this edit the two code descriptions are only marginally different.[6] there is a significant amount of overlap between the denying (Column 1) code and the denied (Column 2) code. The references to the opening of the artery, the creation of the conduit for the delivery of the prosthesis, the two operative approaches, and the unilateral nature of the incision are common to both codes in the edit.

Where the two code narratives *do not overlap* is that code 34820 also references the surgical management of an iliac occlusion in the course of the endovascular surgery. Does the incorporation of the surgical management of the occlusion of the iliac artery in the Column 2's code's descriptor constitute a sufficient condition for a justifiable edit override?

6. On the assumption that, in the near future, CMS will reveal which existing (or new) CCI Edit pairs may be overridden by one and only one X [EPSU) modifier the basis for those selections and the criteria used for those choices should be of interest. The assumption would be that in the case of modifier XU CCI code pairs whose description are only slightly different as in the the example illustrated above will be the focus of attention.

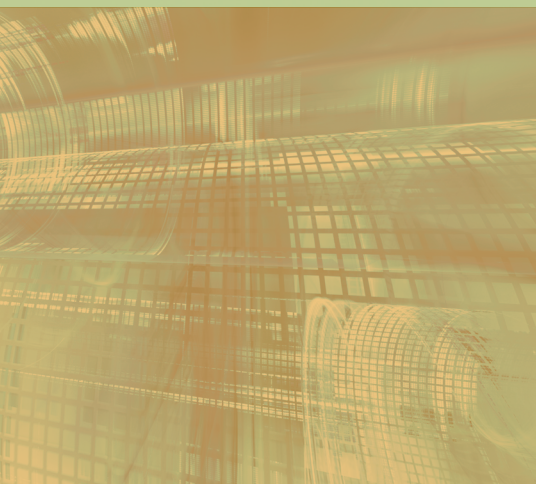
That is, if the occlusion repair was performed in the courses of the operation, will, that justify the placement of Modifier XU on the otherwise denied code in this CCI edit pair? CMS's says no. On the face of it, code 34820 is always denied to code 34883 in the structure of the CCI edit even if the additional surgical management in code 34820 is documented in the operative report. Yet, there is something more!

An important feature of this edit is one typical of most CCI edits. The edit pair 34833/34820 *is susceptible to a modifier over-ride*. Yet CMS's position in the use of modifier XU is inappropriate if it was attached to the Column 2 code 34820 when the placement was based on the surgeon's management of an occlusion of the iliac artery in the course of the endovascular procedure. Why? It is because that component *does not constitute the "main service"* in the edit. The edit's "main service" (e.g., the opening of the artery, the creation of the conduit for the prosthesis) makes up that group of services common to both procedures in this edit pair. The high degree of overlap in the main service components (common to both codes) "trumps" the surgical management.

CMS's Modifier 59 and Modifier XU Policies: The "Take Homes"

What can we conclude from this retrospective review of CMS's historical Modifier 59 policy and its possible implications for Modifier XU? For one, our exercise demonstrates that the starting point for identifying the circumstances that would legitimize the upholding of a XU modifier based edit override starts with a careful review of Column 1 and Column 2 code descriptors in the edit focusing on the constituent service(s) that is non-duplicative. Once that service is identified, the remaining (common) services, by default, are the "Main Services."

As we have seen, the mere presence of that non-duplicative service(s) is itself not sufficient justification to allow both codes to be reportable by way for an edit override. Therefore, one must look for clinical factors that either supplement or lie outside of the code descriptions.



For example, what if the operative report documented the occurrence of major complications in the opening of the iliac occlusion? Would the complication increase the stature of the "minor service" in the edit and negate the significant amount of main service overlap? It is is a question of identifying the exception criteria for modifier overrides and setting some workable guidelines for their application.

Conclusions on CMS's New Policy

For now, without the new edits or further guidance, the principal impact of CMS's "unpacking" of Modifier 59 is to increase the provider's responsibility when he/she submits an edit override modifier. If the provider elects to submit a –X {EPSU} modifier in place of Modifier 59, the provider is now *prospectively differentiating for CMS which* specific component of that "legacy" Modifier 59 is basis for the reported CCI edit override. Such differentiation clearly has some administrative advantages for CMS.

The provider using an X-{ESPU} as an alternative to Modifier 59 "up-front" is providing a more discerning justification for his or hers' edit override. But that simplifies for CMS the manual or automated review of claims with edits override modifiers.

However, whether the reconstituted modifier XU wrapped in its new definition will at the operational level prove to be more transparent and less subject to provider abuse than its predecessor remains an open question. CMS currently allows providers to submit either Modifier 59 or the appropriate –X {EPSU} modifier. This in the near term also masks the new policy's effects. Most importantly, it remains unclear whether, at the coding an claims adjudication level, the rule that there must be, "no overlap with the Main Service" has any more value than CMS's previous admonition that CCI modifier overrides may only take place when the services in the edit are "separate and distinct."

PCG
SOFTWARE

A Primer on the Coding Modifier 59 Subset:

XE, XP, XS and XU

by Andria Jacobs, RN, MS, CEN, CPHQ

PCG Software, Inc.
7065 W. Ann Road, #130-549
Las Vegas, NV 89130

Tel 877.789.1291
Fax 310.456.6871

info@pcgsoftware.com
www.pcgsoftware.com