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: 02/28/2024

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 and established four new subsets of modifier -59: -XE, -XS, -XP and -XU to ensure correct modifier usage and adherence to correct coding guidelines. These 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 type of service rendered due to the widespread inappropriate use of this modifier. Therefore, it is inappropriate to bill both modifier -59 and one of the "X" subset modifiers on the same claim.

Application
This policy applies to hospital and professional claims.

Claims Reimbursement Edit
Code auditing software flags 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 reimbursed or denied for incorrect modifier use.

Documentation Requirements
These modifiers are reviewed for correct coding in the same manner as modifier -59. Because each modifier represents different clinical scenarios, a prepayment review is conducted to look for supporting documentation in the claim and claim history. For example, a review of modifier - XE determines if the clinical situation is likely to require more than one encounter per day. For modifier -XP, the review determines if it is likely the clinical scenario 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. 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)	Service that is distinct because it occurred during a separate encounter
XS (Separate Structure)	Service that is distinct because it was performed on a separate organ/structure
XP (Separate Practitioner)	Service that is distinct because it was performed by a different practitioner
XU (Unusual Non-Overlapping Service)	Service that is distinct because it does not overlap usual components of the main service

References

1. *Current Procedural Terminology (CPT®), 2025*
2. *Centers for Medicare and Medicaid Services (CMS), CMS Manual System and other CMS publications and services*
3. *CMS National Correct Coding Initiative (NCCI) 2025 Coding Policy Manual – Chapter 1* https://www.cms.gov/files/document/medicare-ncci-policy-manual-2024-chapter-1.pdf
4. *CMS MLN17837722 - Proper Use of Modifier 59, XE, XP, XS, XU*

https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf

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
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; no major updates required
12/01/2022	Annual Review completed; formatting updated to eliminate redundancy
11/07/2023	Annual Review completed
02/28/2024	Annual review completed; dates updated, references reviewed, and I added the links for the references and the short description of the modifiers.
11/12/2024	Annual Review completed

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.

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

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.