moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM051
Policy Title:	Procedures Designated as "Separate Procedure"		
Section:	Administrative	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	8/10/2016
Last Updated:	9/11/2024	Last Reviewed:	9/11/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		9/11/2024	

Reimbursement Guidelines

A. General Policy Statement:

If a CPT code descriptor includes the term "separate procedure", the CPT code may not be reported separately with a related procedure. Moda Health follows CMS/NCCI Policy Manual guidelines to determine whether or not the "separate procedure" code is related to the other procedure codes billed.

B. Sole Procedure Code Billed.

Codes designated as "separate procedure" CPT codes are eligible for separate reimbursement when they are the only procedure code reported for that joint, body part, or organ system during that surgical session.

C. Billed In Combination With Other Procedure Codes.

1. Clinical Edit Bundling
   a. Many CCI procedure-to-procedure (PTP) edits deny "separate procedure" CPT codes as included in related comprehensive codes. Some of these edits are eligible for a modifier bypass (modifier indicator of "1"), and others are not (modifier indicator of "0").
   b. Other code combinations do not appear in the CCI PTP edits; the claims processing bundling edits are based upon the separate procedure guidelines found in the CCI Policy Manual (CMS[2]) guidelines.

2. When Separately Allowable with Other Procedure Code(s)

   A CPT code with a descriptor including the term "separate procedure" may be reported with a bypass modifier in combination with a more comprehensive related procedure code when the modifier indicator is a "1" and the following criteria is met:

   a. Modifier XE may be appended when the "separate procedure" service is performed first, the patient leaves the operating room, is recovered, and hours later on the same date of service needs to return to the operating room for a more comprehensive procedure on the same organ system or a related body part.
   b. Modifier XS may be appended when the "separate procedure" service is performed on one side of the body (e.g., left knee) and the more comprehensive, related procedure code is performed on the contralateral (opposite side) of the body (e.g., right knee).
   c. Modifier XS may be appended to a separate procedure code when performed during the same operative session as a more comprehensive related code, but the "separate procedure" service is performed on one lesion and the more comprehensive, related procedure code is performed on a different lesion which is not touching the first lesion (non-contiguous). The two lesions may be located in the same organ (e.g., breast, liver, etc.) or different organs (depending upon the code descriptions involved), or on the skin but not touching or located in a different area.

3. Not Eligible for Bypass-Modifier Usage or Separate Reimbursement

   A code designated as "separate procedure" may not be reported with a modifier for separate reimbursement in combination with a more comprehensive, related procedure when:

   a. Both codes are performed on the same joint or body part during the same operative session.
      i. The use of a separate surgical approach (laparoscopic versus open approach) or a separate incision is not a sufficient reason to use a modifier to obtain separate reimbursement.
      ii. The CMS/CCI guidelines indicate that the use of a separate incision or separate surgical approach alone is not sufficient when the more comprehensive procedure is performed on an anatomically related area.
   b. Both codes are performed during the same operative session, but by different providers.
      i. Separate procedure bundling and guidelines apply to assistant surgeon, co-surgeon, and/or other situations involving multiple surgeons during the same surgical session.
      ii. It is not appropriate to use modifier XP or 59 to bypass separate procedure bundling during the same operative session.
   c. The CCI procedure-to-procedure (PTP) edit is not eligible for a modifier bypass (modifier indicator of "0").

      <u>For Example:</u>

      58805 "Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach."

      This separate procedure may not be reported in combination with other procedure codes for fallopian tubes, ovaries, or other female organs on the same date of service during the

same surgical session. Procedure codes for female organs are considered anatomically related.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
PTP	Procedure To Procedure (a type of NCCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	Uniform Bill

Definition of Terms

Term	Definition
Contralateral	On the opposite side; originating in or affecting the opposite side of the body, the opposite of homolateral and ipsilateral.
Different Anatomic Sites	Different organs, different anatomic regions, or different lesions in the same organ.
Ipsilateral	On the same side; affecting the same side of the body; the opposite of contralateral. In paralysis, this term is used to describe findings on the same side of the body as the brain or spinal cord lesions producing them.
Same Anatomic Site	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. Treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site. [3]

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
Modifier XS	Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
Modifier XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

Modifier	Modifier Description & Definition
Modifier XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
Modifier 59	**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, 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 it 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. **Note:** 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 day, see modifier 25.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent 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)." [1]

"If a CPT code descriptor includes the term "separate procedure", the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach." [2]

"From an NCCI perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. 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." [3]

Cross References

"Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.

References & Resources

1. American Medical Association. "Surgery Guidelines, Separate Procedure." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

2. CMS. "CPT 'Separate Procedure' Definition." *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § J.

3. CMS. "Modifiers and Modifier Indicators, Modifier 59." *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E.1.d.

Background Information

Certain CPT codes are designated as "separate procedure" by the AMA by the inclusion of "(separate procedure)" at the end of the procedure code description. These procedure codes describe common, basic procedures and services that can occasionally be performed as the most comprehensive service provided but are commonly carried out as an integral component of another more comprehensive total service or procedure which is reported with another more comprehensive procedure code.

Separate procedure CPT codes are often incorrectly reported in combination with another more comprehensive related procedure and modifier 59 inappropriately appended. Many people mistakenly believe that when a procedure code description includes "(separate procedure)" this means that the procedure code automatically qualifies for the use of modifier 59 to bypass a bundling edit; this is not correct. The guidelines for when it is appropriate to append a separate and distinct modifier such as modifier 59 to obtain separate reimbursement for a "separate procedure" CPT code are not well understood.

The purpose of this policy is to clarify the standards and guidelines used and applied in claims reviews, adjudication, and appeals.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
9/11/2024	Definition of Terms updated. Formatting updates. No policy changes.
10/11/2023	Cross References updated. Formatting updates. No policy changes.
8/10/2022	Formatting updates. No policy changes.
8/10/2016	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on AMA guidelines & CMS separate procedure policy.