	Reimbursement Policy

Subject: Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)

Effective Date: ~~08/24/15~~[10/31/19]	Committee Approval Obtained: ~~08/24/15~~[10/31/19]	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.healthybluela.com**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Healthy Blue allows reimbursement for a procedure or service that is distinct or independent from other service(s) performed on the same day by the same provider when billed with Modifier 59, XE, XP, XS~~,~~ or XU (collectively known as X{EPSU}) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Healthy Blue follows CMS National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit guidelines.

Reimbursable:

- National Correct Coding Initiative (NCCI) Column 1/Column 2 edits; Modifiers 59 or X{EPSU} may be appended to the paid or denied code.
- Modifier 59 should only be used ~~when a~~if no more descriptive modifier~~, like an XE, XP, XS or XU (collectively referred to as X{EPSU})~~ is ~~not~~ available~~. The X{EPSU} modifiers are more selective versions of~~ such as XE, XP, XS, XU.
- Modifier 59~~; it would~~ should not be ~~incorrect~~appended to ~~include both modifiers on~~ the same claim ~~line.~~lime item as X{EPSU}.

~~Modifier~~	~~Description~~
~~59~~	~~Used to indicate that a procedure or service was distinct or independent from other services performed on the same day; Modifier 59 is used to identify procedures or services that are not normally reported together but are appropriate under the circumstances~~
~~XE~~	~~Separate Encounter; used to indicate a service that is distinct because it occurred during a separate encounter~~
~~XP~~	~~Separate Practitioner; used to indicate a service is distinct because it was performed by a different practitioner~~
~~XS~~	~~Separate Structure; used to indicate a service is distinct because it was performed on a separate organ/structure~~
~~XU~~	~~Unusual Nonoverlapping Service; the use of a service that is distinct because it does not overlap usual components of the main service~~

Healthy Blue reserves the right to perform ~~postpayment~~post-payment review of claims submitted with Modifier 59 and ~~–~~X{EPSU}. ~~We~~Healthy Blue may request that providers submit additional documentation, including medical records or other documentation not directly related to the member, to support claims submitted by the provider. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the episode of care, Healthy Blue may:

- Deny the claim.

	• Recover and/or recoup monies previously paid on the claim. Healthy Blue is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation. ~~**Nonreimbursable**~~ ~~Healthy Blue does not allow reimbursement for the above-listed modifiers in the following circumstances:~~ ~~• The modifier is billed with Evaluation and Management (E&M) codes.~~ ~~• The modifier is billed with radiation therapy management codes.~~ ~~• A different modifier would describe the situation more accurately.~~ ~~**Note:** Refer to individual modifier policies for specific modifier requirements, guidelines, and exemptions.~~
History	• Biennial review approved and effective **10/31/19**: Policy template updated • Effective **09/01/17**: Policy template updated • Initial review approved and effective **08/24/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • American Medical Association: Coding with Modifiers, Fifth Edition • Optum Learning: Understanding Modifiers, ~~2015~~2019 Edition ~~• U.S. Department of Health & Human Services, Office of the Inspector General, Semiannual Report to Congress, October 1, 2005-March 31, 2006~~ • ~~U.S. Department of Health & Human Services, Office of the Inspector General, Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits, OEI-03-02-00771, November 2005~~
Definitions	• **Modifier 59:** 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. Modifier 59 should not be appended to an E/M service

	• **Modifier XE:** Separate encounter, a service that is distinct because it occurred during a separate encounter • **Modifier XP:** Separate practitioner, a service that is distinct because it was performed by a different practitioner • **Modifier XS:** Separate structure, a service that is distinct because it was performed on a separate organ/structure • **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 • **General Reimbursement Policy Definitions**
Related Policies	• ~~Professional Anesthesia Services~~ • Claims Requiring Additional Documentation • Code and Clinical Editing Guidelines • ~~Maternity Services~~ • ~~Modifier 24: Unrelated Evaluation and Management Service by Same Physician During Postoperative Period~~ • ~~Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by Same Physician on Same Day of Procedure or Other Service~~ • ~~Modifier 57: Decision for Surgery~~ • ~~Modifier 78: Unplanned Return to Operating/ Procedure Room by Same Physician Following Initial Procedure for a Related Procedure During Postoperative Period~~ • Documentation Standards for Episodes of Care • Modifier Usage • ~~Multiple and Bilateral Surgery: Professional and Facility Reimbursement~~
Related Materials	• None