	Reimbursement Policy

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

Effective Date:	Committee Approval Obtained:	Section:
01/01/20	**01/01/20**	**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 claims submissions and to outline the basis for reimbursement if the service is covered by a Healthy Blue Dual Advantage (HMO D-SNP) member's 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Healthy Blue Dual Advantage 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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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 set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue Dual Advantage strives to minimize these variations.

Healthy Blue Dual Advantage reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy	Healthy Blue Dual Advantage 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 Dual Advantage 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 if no more descriptive modifier is available such as XE, XP, XS, XU. • Modifier 59 should not be appended to the same claim lime item as X{EPSU}. Healthy Blue Dual Advantage reserves the right to perform post-payment review of claims submitted with Modifier 59 and X{EPSU}. Healthy Blue Dual Advantage 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, we may: • Deny the claim. • Recover and/or recoup monies previously paid on the claim. Healthy Blue Dual Advantage is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.
History	• Initial policy approval and effective date **01/01/20**
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 360 Learning: Understanding Modifiers, 2019 Edition
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	• Claims Requiring Additional Documentation • Code and Clinical Editing Guidelines • Documentation Standards for Episodes of Care • Modifier Usage
Related Materials	• None