Commercial Reimbursement Policy

Subject: **Distinct Procedural Service, Modifiers 59 and XE, XP, XS, & XU - Professional**	
Policy Number: **C-09006**	Policy Section: **Coding**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement 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 member's 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 Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

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

These reimbursement policies may be superseded by mandates in provider, state federal or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for a procedure or service that is distinct or independent from other services 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 contracts and/or requirements indicate otherwise.

The Health Plan 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, and XU.
- Modifier 59 should not be appended to the same claim line item as X{EPSU}

The Health Plan reserves the right to perform post-payment review of claims submitted with Modifier 59 and X{EPSU}. We 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

The Health Plan is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Nonreimbursable:
The Health Plan does not allow reimbursement for Modifiers 59 X{EPSU} in the following circumstances:

- When the denial of a code is supported by CPT parenthetical language that indicates a code is not reportable "with" specific other codes
- When multiple procedures are performed on the same anatomical digit, by the same provider, during the same operative session.
    - Modifiers FA, F1-F9 and TA, T1-T9 should be appended to applicable site-specific services.
- The code (s) listed in the first column when reported with the code(s) listed in the third column of the attached Related Coding table

Related Coding	
Description	**Comment**
Code pairs that do not allow modifiers 59, X (EPSU) override	Code pairs that do not allow modifiers 59, X (EPSU) override

Policy History	
04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated Related Coding section; • added code pair language 96365, 96369, 96372, 96373, 96374, 96379 to deny when reported with 78265, 78830 or 78835 • removed *code pairs to allow ER visits 99281 - 99285 when billed with CPT Codes 700XX-76511, 76513-76603,76605-75699, 76707-76769, 76777-76814, 76816-76856, 76858-76881, 76883-788XX*

10/01/2021	Review approved 10/01/2021 and effective 01/01/2022: added below code pairs to Related Coding section; code pairs do not allow Modifier 59, X{EPSU} override • 43281, 43282, 43283, 43332, 43333 when reported 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888 • Q3014 when reported with any E&M code with Place of Service 11 • 81000-81003, 81005, 82542, 82570, 83516-83520, 83789, 83986, 84156, 84311 when reported with 80305-80307, 80320-80377, 83992, G0480-G0483, G0659 • Added code pairs to the Related Coding section; L8679 with 63650, L8679 with 63655, L8680 with 63655, L8687 with 63650, and L8687 with 63655 • Nonreimbursable section "When multiple procedures are performed on the same anatomic digit, (Modifier FA, F1-F9 and TA, T1-T9), by the same provider, during the same operative session". • Added specimen validity testing codes to the Related Coding section (not eligible for reimbursement when reported with drug testing codes) 81000-81003, 81005, 82542, 82570, 83516-83520, 83789, 83986, 84156, 84311 when reported with 80305-80307, 80320-80377, 83992, G0480-G0483, G0659.
10/01/2020	Review approved 10/01/2020 and effective 01/01/2021: added below code pairs to Related Coding section: • 29822 reported with 29819, 29820, 29824, 29825, 29827 • 29823 reported with 29806, 29807, 29819, 29820, 29821, 29825 • 29837-29838 reported with 29834, 29835, 29836 • 76942 reported with 20551, 20551, 20552, 20553 • 63048 when reported 22630, 22633 • 63081-63088 when report with 22558 as support code that will deny • 82542 reported with 80320-80377, 83992, G0480-G0483, G0659 • 95957 reported with 95951, 95953, 95954, 95956
05/29/2020	Added 82542 when reported with 80305-80307 to the Related Coding section. Edit in place effective 2017, policy was not updated.
03/31/2020	Added below code pairs to Related Coding section: • 01996 reported with 62320-62327 • 82570 reported with 80305-80307, 80320-80377, 83992, G0480-G0483, or G0659 • 83986 reported with 80305-80307, 80320-80377, 83992, G0480-G0483, or G0659 • 76942, 77002, 77003, 77012, 77021 reported with 62320, 62322, 62324, and 62326 • 77002 reported with 62321, 62323, 62325, and 62327 • G0480, G0481, G0482, or G0483 reported with G0659 Edits in place effective 2017, policy was not updated

10/31/2019	Review approved: updated policy language for NCCI Procedure to Procedure Column One and Column Two Codes, removed all “and” “or” language from Related Coding section, aligned policy language, Removed Moderate Sedation references and exemptions
05/15/2019	Review approved: converted to new policy template; removed description section, added definition section, reviewed and updated all exceptions in the Exceptions to Distinct Procedure Modifier Override Section, removed exceptions indicated as Parenthetical Language in the CPT Codebook, Removed “*L8680 reported with 63650” not adopted by any market*, removed reference to section 3 of the Bundled Services policy
05/04/2018	Update policy language for Exceptions to Distinct Procedure Modifier Override Section
07/11/2017	Revised: Add denial of U/S guidance 76942 when reported with trigger point injections 20552 and 20553 is not overridden with modifiers to Exceptions to Distinct Procedure Modifier Override Section
06/06/2017	Revised: Add coding for shoulder and elbow arthroscopic debridement codes not allowed with arthroscopic surgery and no modifier override to Exceptions to Distinct Procedure Modifier Override Section
04/04/2017	Revised: Updated Exceptions to Distinct Procedure Modifier Override Section codes for the drug testing edits
02/07/2017	Revised: Add 2017 spinal injection codes to Exceptions to Distinct Procedure Modifier Override Section
10/04/2016	Revised: Add codes to Exceptions to Distinct Procedure Modifier Override Section
09/06/2016	Revised: Updated and Edited Rule 26, : Add codes to Exceptions to Distinct Procedure Modifier Override Section
08/02/2016	Revised: Add codes to Exceptions to Distinct Procedure Modifier Override Section
05/03/2016	Revised: Add Parenthetical language to Exceptions to Distinct Procedure Modifier Override Section
04/05/2016	Revised: Add codes to Exceptions to Distinct Procedure Modifier Override Section
02/02/2016	Revised: Exceptions to Distinct Procedure Modifier Override Section 58140, 58145, 58146, 58545, 58546 and 58561 reported with 58570, 58571, 58572 or 58573
01/05/2016	Revised: Cross reference Bundled Services Policy add codes to Exceptions to Distinct Procedure Modifier Override Section
12/01/2015	Revised: Add codes to Exceptions to Distinct Procedure Modifier Override Section
10/06/2015	Revised: Add codes to Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
07/07/2015	Revised: Aligned codes with Bundled Services Policy, updated Exceptions to Distinct Procedure Modifier Override Section
06/02/2015	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section

04/07/2015	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
01/06/2015	Revised: Updated title to include modifiers X{EPSU} , Add a high-level description X modifiers. Updated Exceptions to Distinct Procedure Modifier Override Section
11/04/2014	Revised: Aligned with changes to Bundled Services Policy, updated codes in the Exceptions to Distinct Procedure Modifier Override Section
09/02/2014	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
07/01/2014	Revised: Updated Description Section and add codes to the Exceptions to Distinct Procedure Modifier Override Section
06/03/2014	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
05/06/2014	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
03/04/2014	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
02/04/2014	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
11/05/2013	Revised: Aligned codes with Bundled Services Policy updated Exceptions to Distinct Procedure Modifier Override Section
08/06/2013	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section, placed codes in numerical order
05/07/2013	Revised: Updated language in Reporting and Documentation Rules and Criteria for Modifier 59 Section, updated Exceptions to Distinct Procedure Modifier Override Section
01/08/2013	Revised: Updated language and codes in Exceptions to Distinct Procedure Modifier Override Section
11/06/2012	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
08/07/2012	Revised: Updated language in Policy and Exceptions to Distinct Procedure Modifier Override Sections
08/02/2011	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
02/01/2011	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
01/14/2011	Revised: Updated language in Reporting and Documentation Rules and Criteria for Modifier 59 Section
10/05/2010	Revised: Add codes Exceptions to Distinct Procedure Modifier Override Section
08/04/2009	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA) Current Procedural Terminology (CPT®) Professional Edition 2021

- American Academy of Professional Coders (AAPC) HCPCS Level II 2021
- American Academy of Orthopedic Surgeons
- CMS
- National Correct Coding Initiative Edits (NCCI)
- Optum EncoderPro 2021

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
Procedure Unbundling	When two or more procedure codes are used to describe a service when a single, more comprehensive procedure code exists that more accurately describes the complete service performed. Procedure unbundling edits include three components: Incidental, Mutually Exclusive, and Rebundling.
General Reimbursement Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies - Professional
Code and Clinical Editing - Professional
Multiple Delivery Services - Professional
Screening Services with Evaluation and Management - Professional

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.