Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC, HARP, and CHPlus programs only.

Reimbursement Policy	
Subject: **Modifiers 59, XE, XP, XS, XU: Distinct Procedural Services**	
Policy Number: **G-15001**	Policy Section: **Coding**
Last Approval Date: **05/22/2024**	Effective Date: **04/12/2022**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providerpublic.mybcbswny.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the 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, Highmark BCBS may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or

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requirements. Highmark BCBS strives 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

Highmark BCBS 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.

Highmark BCBS 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 line item as X{EPSU}.

Highmark BCBS reserves the right to perform post-payment review of claims submitted with Modifier 59 and X{EPSU}. Highmark BCBS 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.

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

Related Coding
Standard correct coding applies

Policy History	
05/22/2024	Review approved: updated policy title from Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)
04/12/2022	Review approved and effective: updated policy template, no changes to policy language
10/31/2019	Review approved and effective: policy template updated
08/31/2017	Review approved: Policy template updated
08/24/2015	Initial approved 08/24/2015 and effective 01/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association: Coding with Modifiers, Sixth Edition
- CMS
- Optum Learning: Understanding Modifiers, 2024 Edition
- State contract
- State Medicaid

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 and Materials
Claims Requiring Additional Documentation
Code and Clinical Editing Guidelines
Documentation Standards for Episodes of Care
Modifier Usage