Professional Pricing Policy	
Subject: **Distinct Procedural Services- Modifiers 59, XE, XP, XS, XU**	
Policy Number: HLCP-0002	Policy Section: **Coding**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. 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. 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. 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.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

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

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink 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. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

HealthLink allows 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 CMS contracts and/or requirements indicate otherwise.

HealthLink follows CMS National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edit guidelines.

Allowed:

- 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}

HealthLink and HealthLink payors reserve 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.

Not Allowed:

HealthLink does not allow 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
- The code (s) listed in the first column when reported with the code(s) listed in the third column of the Related Coding table.

Related Coding – Use ONLY if expressly needed

Code	Description	Comment
22612	Reported with	22633
36000	Reported with	96360, 96365, 96374, 96375,96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, 96542
700XX-788XX, G01XX- G03XX, S8035-S8092, S9024 (these code ranges include all applicable radiology interpretation codes, as well as radiology codes with modifier 26)	Reported with	99281-99285
77002	Reported with	62321, 62323, 62325, 62327
77014	Reported with	77280, 77285, 77290
77427	Reported with	Any other supply
80321	Reported with	80322
80324	Reported with	80325, 80326
80325	Reported with	80326
80327	Reported with	80328
80329	Reported with	80330, 80331
80330	Reported with	80331
80332	Reported with	80333, 80334
80333	Reported with	80334
80335	Reported with	80336, 80337
80336	Reported with	80337
80339	Reported with	80340, 80341
80340	Reported with	80341
80342	Reported with	80343, 80344
80343	Reported with	80344
80346	Reported with	80347
80350	Reported with	80351, 80352
80351	Reported with	80352
80362	Reported with	80363, 80364
80363	Reported with	80364
80369	Reported with	80370
80375	Reported with	80376, 80377
80376	Reported with	80377
92531, 92532, 94150, 94664, 96523	Reported with	Any other procedure, service, or supply

Code	Description	Comment
93010, 93018, 93042	Reported with	99281-99285
95940	Reported with	95941
A4221, A4222, E0776, E0781, S9810	Reported with	Any per diem home infusion therapy (HIT) code such as S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590
A4250	Reported with	Urinalysis codes 81000-81003
A4556, A4557	Reported with	A4595 (same date of service and/or within a 30 day period) electrical stimulator supplies
A4556	Reported with	Related electrical cardiography codes 93XXX; neurology, sleep study, and neuromuscular codes 95XXX; electrical stimulation codes 97014, 97032, 97033, 97813, 97814; home sleep studies G0398-G0400
A4595	Reported with	97014, 97032
A4648	Reported with	19081-19101, 19281-19288
L8680	Reported with	63650
Q0091	Reported with	99381-99397, 99201-99205, S0610-S0613

Exemptions

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 Professional Pricing Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies
Claim Editing Overview
Screening Services with Evaluation and Management Services

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- Healthcare Common Procedural Coding System (HCPCS Level II)
- American Medical Association (AMA) Current Procedural Terminology (CPT)
- American Academy of Professional Coders (AAPC) HCPCS Level II
- American Academy of Orthopedic Surgeons
- CMS National Correct Coding Initiative Edits (NCCI)
- Optum 360 EncoderPro

Use of Pricing 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. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.