REIMBURSEMENT POLICY STATEMENT
D-SNP

Policy Name & Number	Date Effective
Modifier 59, XE, XP, XS, XU-DSNP-PY-1376	10/01/2025
	Ohio inactive as of 01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):	
☒ **Georgia**	☒ **Ohio**

Table of Contents

A. Subject
Modifier 59, XE, XP, XS, XU

B. Background
Reimbursement policies are designed to assist physicians when submitting claims to CareSource. They are routinely updated to promote accurate coding and provide policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing.

Reimbursement modifiers are 2-digit codes that provide a way for physicians and other qualified health care professionals to indicate that a service or procedure has been altered by some specific circumstance. Although CareSource accepts the use of modifiers, their use does not guarantee reimbursement. Some modifiers increase or decrease the reimbursement rate, while others do not affect the reimbursement rate. CareSource may verify the use of any modifier through prepayment and post-payment audit. Using a modifier inappropriately can result in the denial of a claim or an incorrect reimbursement for a product or service. All information regarding the use of these modifiers must be made available upon CareSource's request.

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure edits that define when 2 Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®) codes should not be reported together either in all situations or in most situations. Modifier 59 is used to identify procedures/services, other than evaluation and management (E/M) services, that are not usually reported together, but are appropriate under the patient's specific circumstance. National Correct Coding Initiative (NCCI) guidelines state that providers should not use modifier 59 solely because 2 different procedures/surgeries are performed or because the CPT® codes are different procedures. Modifier 59 should only be used if the 2 procedures/surgeries are performed at separate anatomic sites, at separate patient encounters, or by different practitioners on the same date of service. Contiguous anatomic sites are not considered separate in this circumstance.

The Centers for Medicare and Medicaid Services (CMS) established four HCPCS modifiers to define specific subsets of modifier 59:

- XE – Separate Encounter, a service that is distinct because it occurred during a separate encounter
- XP – Separate Practitioner, a service that is distinct because it was performed by a different practitioner
- XS – Separate Structure, a service that is distinct because it was performed on a separate organ/structure
- XU – Unusual Non-Overlapping Service, a service that is distinct because it does not overlap usual components of the main service.

CPT® instructions state that modifier 59 should only be used if no more descriptive modifier is available, and its use best explains the coding circumstances. Providers should use the more specific X {EPSU} modifier when appropriate CMS guidelines note that the X modifiers are more selective versions of modifier 59.

C. Definitions

- **Current Procedural Terminology (CPT®)** – Codes that are issued, updated, and maintained by the American Medical Association (AMA) that provide a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated, and maintained by the AMA that provides a standard language for coding and billing products, supplies, and services not included in the CPT® codes.
- **Modifier** – A 2-character code used along with a CPT® or HCPCS code to provide additional information about the service or procedure rendered.

D. Policy

I. CareSource reserves the right to review any submission at any time to ensure correct coding standards and guidelines are met.

II. Provider claims billed with modifier 59 or X {EPSU} may be flagged for either a prepayment clinical validation or post-payment medical record coding review.
   A. For prepayment review, once the claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.
   B. For post-payment review, once the review has been completed, a decision is made based on the submitted documentation. If the claim is not supported by the documentation, CareSource will recover the payment, when applicable.

III. It is the responsibility of the submitting provider to submit accurate documentation to substantiate the coding of their claim. Failure to submit accurate and complete documentation may result in a denial. If the documentation does not support the claims submission, this will also result in a claims denial.

IV. Standard appeal rights apply for both pre- and post-payment findings and outcome of the review.

V. Modifiers X {EPSU} should be used prior to using modifier 59.

VI. Modifier X {EPSU} (or 59, when applicable) may only be used to indicate that a distinct procedural service was performed independent from other non-E/M services performed on the same day when no other more appropriate modifier is available. Documentation should support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same provider, provider group, and/or provider specialty.
   A. Modifier XS (or 59, when applicable) is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that meets all the following:

1. are performed at different anatomic sites
2. are not ordinarily performed or encountered on the same day
3. cannot be described by 1 of the more specific anatomic NCCI Procedure to Procedure (PTP)-associated modifiers (ie, RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, RI)

B. Modifier XE (or 59, when applicable) is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that meet all the following:
   1. are performed during different patient encounters
   2. cannot be described by 1 of the more specific NCCI PTP-associated modifiers (ie, 24, 25, 27, 57, 58, 78, 79, 91)

C. Modifier XE (or 59, when applicable) may also be used when 2 timed procedures are performed during the same encounter but occur 1 after another (the first service must be completed before the next service begins).

D. Modifier XU (or 59, when applicable) is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are either
   1. performed at separate anatomic sites
   2. performed at separate patient encounters on the same date of service

E. Modifier XU (or 59, when applicable) may be used when a diagnostic procedure is performed before a therapeutic procedure only when all the following apply:
   1. diagnostic procedure is the basis for performing the therapeutic procedure
   2. occurs before the therapeutic procedure and is not mingled with services the therapeutic intervention requires
   3. provides clearly the information needed to decide whether to proceed with the therapeutic procedure
   4. does not constitute a service that would have otherwise been required during the therapeutic intervention (If the diagnostic procedure is an inherent component of the surgical procedure, it cannot be reported separately.)

F. Modifiers XU (or 59, when applicable) may be used when a diagnostic procedure is performed after a therapeutic procedure only when all the following apply:
   1. diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure
   2. occurs after the completion of the therapeutic procedure and is not mingled with or otherwise mixed with services that the therapeutic intervention requires
   3. does not constitute a service that would have otherwise been required during the therapeutic intervention (If the post-procedure diagnostic procedure is an inherent component or otherwise included (eg, not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it cannot be reported separately.)

E. State-Specific Information

NA

F. Conditions of Coverage

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT® codes along with appropriate modifiers, if applicable. In the absence of state

specific instructions, the CMS guidelines will apply. Please refer to the individual fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claims submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, this policy applies to both participating and nonparticipating providers and facilities.

In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

G. Related Policies/Rules

Modifiers

H. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2022	
Date Revised	08/02/2023 07/17/2024 07/16/2025	Annual review: updated references. Approved at Committee Review: updated references, approved at Committee Review: updated references, approved at Committee
Date Effective	10/01/2025	
Date Archived		

I. References

1. *General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services.* US Centers for Medicare and Medicaid Services; 2025. Accessed June 27, 2025. www.cms.gov
2. Mechanized Claims Processing and Information Retrieval Systems; Operational, etc., Requirements, 42. U.S.C. § 1396b(r) (2024).
3. *Medicare Claims Processing Manual Chapter 12 – Physicians/Nonphysician Practitioners*. US Centers for Medicare and Medicaid Services; 2024. Accessed June 27, 2025. www.cms.gov
4. *Medicare National Correct Coding Initiative (NCCI) Edits.* US Centers for Medicare and Medicaid Services. Updated April 11, 2025. Accessed June 27, 2025. www.cms.gov
5. *MLN1783722 - Proper Use of Modifiers 59 & -X{EPSU}.* US Centers for Medicare & Medicaid Services; 2024. Accessed June 27, 2025. www.cms.gov
6. *Transmittal R1422OTN - Publication 100-20 - MM8863 - Specific Modifiers for Distinct Procedural Services.* US Centers for Medicare and Medicaid Services; 2014. Accessed June 27, 2025. www.cms.gov