CareSource

REIMBURSEMENT POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Modifier 59, XE, XP, XS, XU-IN MCD-PY-1366	09/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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

B. Background
Reimbursement modifiers are 2-character codes used by physicians and other qualified health care professionals to indicate that a service or procedure has been altered due to a specific circumstance. Although CareSource accepts the use of modifiers, 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 4 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) and 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 pre-payment or post-payment coding review.
   a. For pre-payment review, once the claim line has been validated, it is either processed 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 line 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 the claim. Failure to submit accurate and complete documentation may result in a denial. If the documentation does not support the claim submission, this will also result in a 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. Conditions of Coverage

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, when applicable. In the absence of state specific instructions, the CMS guidelines on Modifier 59, XE, XP, XS, XU 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.

F. Related Policies/Rules

Modifiers

G. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2022	
Date Revised	08/02/2023 07/17/2024 07/16/2025 04/08/2026	Annual review: updated references, approved at Committee Review: updated references, approved at Committee Review: updated references, approved at Committee. Annual Review. Updated reference. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

1. *Claim Submission and Processing*. Indiana Health Coverage Programs Provider Reference Module. July 1, 2024. March 13, 2026. www.in.gov
2. *General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services*. US Centers for Medicare and Medicaid Services; 2025. Accessed March 13, 2026. www.cms.gov
3. *Mechanized Claims Processing and Information Retrieval Systems; Operational, etc., Requirements, 42. U.S.C. § 1396b(r) (2026).*
4. *Medicare Claims Processing Manual Chapter 12 – Physicians/Nonphysician Practitioners.* US Centers for Medicare & Medicaid Services; Accessed March 13, 2026. www.cms.gov
5. *Medicare National Correct Coding Initiative (NCCI) Edits.* US Centers for Medicare and Medicaid Services. Updated January 1, 2026. Accessed March 13, 2026. www.cms.gov
6. *MLN1783722 - Proper Use of Modifiers 59 & -X{EPSU}.* US Centers for Medicare and Medicaid Services; 2025. Accessed February 16, 2026. www.cms.gov
7. *Provider Code Tables*. Indiana Health Coverage Programs. June 1, 2025. Accessed March 13, 2026. www.provider.indianamedicaid.com
8. *Transmittal R1422OTN - Publication 100-20 - MM8863 - Specific Modifiers for Distinct Procedural Services.* US Centers for Medicare and Medicaid Services; 2014. Accessed March 13, 2026. www.cms.gov

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.