Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)		
Effective Date: **10/31/19**	Committee Approval Obtained: **10/31/19**	Section: **Coding**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 CPT® codes, 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; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage 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. Amerigroup Medicare Advantage 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}. Amerigroup Medicare Advantage reserves the right to perform postpayment review of claims submitted with Modifier 59 and X{EPSU}. Amerigroup Medicare Advantage 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, Amerigroup Medicare Advantage may: • Deny the claim. • Recover and/or recoup monies previously paid on the claim. Amerigroup Medicare Advantage is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.
History	• Biennial review approved and effective **10/31/19**: Policy template updated • Biennial review approved **08/31/17**: Policy template updated • Initial policy approval and effective date **08/24/15**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • American Medical Association: Coding with Modifiers, fifth edition • Optum 360 Learning: Understanding Modifiers, 2019 edition
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	• Claims Requiring Additional Documentation • Code and Clinical Editing Guidelines • Documentation Standards for Episodes of Care • Modifier Usage
Related Materials	• None