REIMBURSEMENT POLICY STATEMENT
North Carolina Marketplace

Policy Name & Number	Date Effective
Modifier 59, XE, XP, XS, XU-NC MP-PY-1397	11/01/2023
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.

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The REIMBURSEMENT Policy

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 – Two-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

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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

Modifier 25
Modifiers

G. Review/Revision History

DATE	ACTION
Date Issued	

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