REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Modifier 59, XE, XP, XS, XU-MP-PY-1367	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

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 two-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 P R G L I L H U V P X V W E H P D G H D Y D P X P X P V táDøUt”¦• Q

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.

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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.

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G. Related Policies/Rules

Modifier 25
Modifiers

H.

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

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