Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-009		
Subject:	Modifiers 25, 59, XE, XP, XS XU, and FT		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	January 26, 2026	**Revised Date:**	January 2026
Date Reviewed:	January 2026		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan.

PURPOSE:

This policy addresses coverage guidelines for services considered adjunctive to a basic service and system logic that enforces code combinations when modifiers 25, 59, XE, XP, XS, XU or FT are present on the claim. These guidelines are based on Centers for Medicare and Medicaid Services (CMS), the National Council on Compensation Insurance (NCCI), and/or Plan direction.

REIMBURSEMENT GUIDELINES:

After-Hours Codes

Coverage for special services is determined according to individual or group customer benefits. Special services are those provided at times other than regularly scheduled hours. The following codes describe the specific circumstance under which a basic service is performed and do not represent separately identifiable services:

- **99050** - Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service.
- **99051** - Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.
- **99053** - Service(s) provided between 10:00PM and 8:00AM at 24-hour facility, in addition to basic service.
- **99056** - Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.
- **99058** - Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.

- **99060** - Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

"After hours" is defined as any service(s) rendered outside of regularly scheduled office hours (each practice must publish their hours, and a patient must be seen outside of those standard times as an exception to qualify as after hours). The Health Plan does not designate a special status to holidays. If a holiday falls on a weekday when the office is already open and seeing patients, then the service would not qualify as outside of regularly scheduled office hours and eligible for after-hours reimbursement. If a holiday falls on a weekend, and the office does not have weekend hours, the service would be eligible for after-hours. When eligible, the guidelines of the provider's plan contract will apply when reporting these charges.

When special services are reported with a basic service, the special service charges will be denied, and reimbursement will be made only for the basic service.

In addition, when these special services codes are reported independently, they are not eligible for reimbursement as they do not represent separately identifiable services, but rather adjunctive services or the circumstances during which a basic service was rendered.

The "After Hours" procedure codes will not be reimbursed, regardless of the presence of Modifier 25 on the claim line. Modifier 25 should not be appended to an Evaluation and Management (E/M) service when billed with codes 99050, 99051, 99053, 99056, 99058 and 99060 as these codes do not describe separately identifiable services. See more information below on modifier 25.

Note: Effective January 1, 2026, exceptions may apply for code 99051 in New York only.

Modifiers 59, XE, XP, XS, XU and FT

CMS NCCI edits indicate when the presence of an override modifier is permitted to bypass code combination logic, and to allow separate reimbursement for both the combination code and the component code. When NCCI indicates code combinations that are never allowed separate reimbursement for both procedures, our reimbursement will be limited to the allowance of the higher paying procedure of the code combination. In these instances, Modifiers 59, XE, XP, XS, XU and FT will not be allowed to override the code combination. This involves claims for the same patient, same date of service and the same provider specialty.

Modifier FT

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Modifier 25 and FT

Physical Medicine & Manipulation Evaluations:

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work.

Therefore, a separate Evaluation and Management (E/M) service must be medically necessary and be reported at an appropriate coding level. A separate E/M service should not be routinely reported with manipulation, therapy evaluation or time-based physical medicine services. This means that a separate Evaluation and Management (E/M) service should only be considered for payment in the following circumstances:

- Initial examination of a new patient or condition; **or**
- Re-examination of a new patient within an episode of care to assess patient progress, current clinical status, and determine the need for any further medically necessary therapeutic level care; **or**
- Acute exacerbation of symptoms or a significant change in the patient's condition; **or**
- Distinctly different indications, which are separately identifiable and unrelated to the manipulation

For the circumstances described above, modifier 25 or FT may be reported with medical care (e.g. E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 or FT is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Modifier 25 and FT exceptions

Per Medical Policy Y-9, manipulation and physical medicine services inherently include an assessment with clinical criteria documented when a separate Evaluation and Management (E/M) service could be paid under defined circumstances by reporting the 25 or FT modifier. Please note the following exceptions:

Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 or FT modifier on the same day as chiropractic manipulative treatment (98940-98943) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 or FT modifier on the same day as physical therapy, occupational therapy, or athletic training evaluation codes (97161-97172) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Note: For purposes of a written appeal with medical records, medical decision making will be used as one of the two criteria used to score the level of visit (99214/99215) reported.

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
59	Distinct procedural service.
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit. Report when an E&M visit is furnished within the global period but is unrelated, or when one or more additional E&M visits furnished on the same day are unrelated.
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, the use of a service that is distinct because it does not overlap usual components of the main service.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Y-1: Physical Medicine
- Y-2: Occupational Therapy (OT)
- Y-9: Manipulation Services

Refer to the following Reimbursement Policies for additional information:

- RP-014: Multiple Surgical Procedures
- RP-035: Correct Coding Guidelines

POLICY UPDATE HISTORY INFORMATION:

2 / 2017	Implementation
9 / 2020	Note added for after-hours care
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added modifier FT
4 / 2023	Administrative review, no changes in policy direction
4 / 2024	Administrative review, no changes in policy direction
1 / 2026	Added exception note for 99051 applicable to New York only

IMPORTANT INFORMATION

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the member's contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations.

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-009		
Subject:	Modifiers 25, 59, XE, XP, XS XU, and FT		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	April 29, 2024	**Revised Date:**	April 2024
Date Reviewed:	April 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Claim Type	**UB**	☐	**1500**	☒				

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Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy addresses coverage guidelines for services considered adjunctive to a basic service and system logic that enforces code combinations when modifiers 25, 59, XE, XP, XS, XU or FT are present on the claim. These guidelines are based on Centers for Medicare and Medicaid Services (CMS), the National Council on Compensation Insurance (NCCI), and/or Plan direction.

REIMBURSEMENT GUIDELINES:

<u>After Hours Codes</u>

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- **99050** - Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service.
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When special services are reported with a basic service, the special service charges will be denied and payment will be made only for the basic service.

In addition, when these special services codes are reported independently they are not eligible for reimbursement as they do not represent separately identifiable services, but rather adjunctive services or the circumstances during which a basic service was rendered.

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Modifiers 59, XE, XP, XS, XU and FT

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Modifier 25 and FT

Physical Medicine & Manipulation Evaluations:

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate Evaluation and Management (E/M) service must be medically necessary and be

reported at an appropriate coding level. A separate E/M service should not be routinely reported with manipulation, therapy evaluation or time-based physical medicine services. This means that a separate Evaluation and Management (E/M) service should only be considered for payment in the following circumstances:

- Initial examination of a new patient or condition; **or**
- Re-examination of a new patient within an episode of care to assess patient progress, current clinical status, and determine the need for any further medically necessary therapeutic level care; **or**
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- Distinctly different indications, which are separately identifiable and unrelated to the manipulation

For the circumstances described above, modifier 25 or FT may be reported with medical care (e.g. E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 or FT is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Modifier 25 and FT exceptions

Per Medical Policy Y-9, manipulation and physical medicine services inherently include an assessment with clinical criteria documented when a separate Evaluation and Management (E/M) service could be paid under defined circumstances by reporting the 25 or FT modifier. Please note the following exceptions:

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DEFINITIONS:

Modifier	Definition
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RELATED POLICIES:

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POLICY UPDATE HISTORY INFORMATION:

2 / 2017	Implementation
9 / 2020	Note added for after-hours care
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added modifier FT
4 / 2023	Administrative review, no changes in policy direction
4 / 2024	Administrative review, no changes in policy direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-009		
Subject:	Modifiers 25, 59, XE, XP, XS XU, and FT		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	April 24, 2023	**Revised Date:**	April 2023
Date Reviewed:	April 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Claim Type	**UB**	☐	**1500**	☒				

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PURPOSE:

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REIMBURSEMENT GUIDELINES:

After Hours Codes

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Modifier FT

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Modifier 25 and FT

Physical Medicine & Manipulation Evaluations:

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate Evaluation and Management (E/M) service must be medically necessary and be reported at an appropriate coding level. A separate E/M service should not be routinely reported with manipulation, therapy evaluation or time-based physical medicine services. This means that a separate Evaluation and Management (E/M) service should only be considered for payment in the following circumstances:

- Initial examination of a new patient or condition; **or**
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- Acute exacerbation of symptoms or a significant change in the patient's condition; **or**
- Distinctly different indications, which are separately identifiable and unrelated to the manipulation

For the circumstances described above, modifier 25 or FT may be reported with medical care (e.g. E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier 25 or FT is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

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RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Y-1: Physical Medicine
- Y-2: Occupational Therapy (OT)
- Y-9: Manipulation Services

Refer to the following Reimbursement Policies for additional information:

- RP-014: Multiple Surgical Procedures

POLICY UPDATE HISTORY INFORMATION:

2 / 2017	Implementation
9 / 2020	Note added for after hours care
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added modifier FT
4 / 2023	Policy reviewed no changes made

Highmark Reimbursement Policy Bulletin

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Bulletin Number:	RP-009		
Subject:	Modifiers 25, 59, XE, XP, XS XU, and FT		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	December 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
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Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 or FT modifier on the same day as physical therapy, occupational therapy, or athletic training evaluation codes (97161-97172) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Note: For purposes of a written appeal with medical records, medical decision making will be used as one of the two criteria used to score the level of visit (99214/99215) reported.

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Y-1: Physical Medicine
- Y-2: Occupational Therapy (OT)
- Y-9: Manipulation Services

Refer to the following Reimbursement Policies for additional information:

- RP-014: Multiple Surgical Procedures

POLICY UPDATE HISTORY INFORMATION:

2 / 2017	Implementation
9 / 2020	Note added for after hours care
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added modifier FT

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP- 009		
Subject:	Modifiers 25, 59, XE, XP, XS and XU		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy addresses coverage guidelines for services considered adjunctive to a basic service and systems logic that enforces code combinations when Modifiers 25, 59, XE, XP, XS or XU are present on the claim based on CMS NCCI and/or Highmark direction.

REIMBURSEMENT GUIDELINES:

<u>After Hours Codes</u>

Coverage for special services is determined according to individual or group customer benefits. Special services are those provided at times other than regularly scheduled hours. The following codes describe the specific circumstance under which a basic service is performed and do not represent separately identifiable services:

- **99050** - Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service.
- **99051** - Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.
- **99053** - Service(s) provided between 10:00PM and 8:00AM at 24-hour facility, in addition to basic service.
- **99056** - Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.

- **99058** - Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.
- **99060** - Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

*Note: "After hours" is defined as any service(s) rendered outside of regularly scheduled office hours (each practice must publish their hours and a patient must be seen outside of those standard times as an exception to qualify as after hours). The Health Plan does not designate a special status to holidays. If a holiday falls on a weekday when the office would already be open and seeing patients, then the service would not qualify as outside of regularly scheduled office hours and be eligible for after hours reimbursement. If a holiday falls on a weekend, and the office does not have weekend hours, the service would be eligible for after hours. When eligible, the guidelines of the provider's plan contract will apply when reporting these charges.

When special services are reported with a basic service, the special service charges will be denied and payment will be made only for the basic service.

In addition, when these special services codes are reported independently they are not eligible for reimbursement as they do not represent separately identifiable services, but rather adjunctive services or the circumstances during which a basic service was rendered.

The "After Hours" procedure codes will not be reimbursed, regardless of the presence of Modifier 25 on the claim line. Modifier 25 should not be appended to an Evaluation and Management (E/M) service when billed with codes 99050, 99051, 99053, 99056, 99058 and 99060 as these codes do not describe separately identifiable services. See more information below on modifier 25.

Modifiers 59, XE, XP, XS and XU

CMS NCCI edits indicate when the presence of an override modifier is permitted to bypass code combination logic, and to allow separate reimbursement for both the combination code and the component code. When NCCI indicates code combinations that are never allowed separate reimbursement for both procedures, our reimbursement will be limited to the allowance of the higher paying procedure of the code combination. In these instances, Modifiers 59, XE, XP, XS and XU will not be allowed to override the code combination. This involves claims for the same patient, same date of service and the same provider specialty.

Modifier 25

Physical Medicine & Manipulation Evaluations:

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate Evaluation and Management (E/M) service must be medically necessary and be reported at an appropriate coding level. A separate E/M service should not be routinely reported with manipulation, therapy evaluation or time-based physical medicine services. This means that a separate Evaluation and Management (E/M) service should only be considered for payment in the following circumstances:

- Initial examination of a new patient or condition; **or**

- Re-examination of a new patient within an episode of care to assess patient progress, current clinical status, and determine the need for any further medically necessary therapeutic level care; **or**
- Acute exacerbation of symptoms or a significant change in the patient's condition; **or**
- Distinctly different indications, which are separately identifiable and unrelated to the manipulation

Modifier "25" for the circumstances described above may be reported with medical care (e.g. consultations, E/M visits to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier "25" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Modifier 25 exceptions

Per Medical Policy Y-9, manipulation and physical medicine services inherently include an assessment with clinical criteria documented when a separate Evaluation and Management (E/M) service could be paid under defined circumstances by reporting the 25 modifier. Please note the following exceptions:

Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 modifier on the same day as chiropractic manipulative treatment (98940-98943) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 modifier on the same day as physical therapy, occupational therapy, or athletic training evaluation codes (97161-97172) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Note: For purposes of a written appeal with medical records, medical decision making will be used as one of the two criteria used to score the level of visit (99214/99215) reported.

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Y-1: Physical Medicine
- Y-2: Occupational Therapy (OT)
- Y-9: Manipulation Services

Refer to the following Reimbursement Policies for additional information:

- RP-014: Multiple Surgical Procedures

POLICY UPDATE HISTORY INFORMATION:

2 / 2017	Implementation
9 / 2020	Note added for after hours care

11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-009		
Subject:	Modifiers 25, 59, XE, XP, XS and XU		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	November 1, 2020	**Revised Date:**	September 2020
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy addresses coverage guidelines for services considered adjunctive to a basic service and systems logic that enforces code combinations when Modifiers 25, 59, XE, XP, XS or XU are present on the claim based on CMS NCCI and/or Highmark direction.

REIMBURSEMENT GUIDELINES:

<u>After Hours Codes</u>

Coverage for special services is determined according to individual or group customer benefits. Special services are those provided at times other than regularly scheduled hours. The following codes describe the specific circumstance under which a basic service is performed and do not represent separately identifiable services:

- **99050** - Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service.
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- **99060** - Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

*Note: "After hours" is defined as any service(s) rendered outside of regularly scheduled office hours (each practice must publish their hours and a patient must be seen outside of those standard times as an exception to qualify as after hours). The Health Plan does not designate a special status to holidays. If a holiday falls on a weekday when the office would already be open and seeing patients, then the service would not qualify as outside of regularly scheduled office hours and be eligible for after hours reimbursement. If a holiday falls on a weekend, and the office does not have weekend hours, the service would be eligible for after hours. When eligible, the guidelines of the provider's plan contract will apply when reporting these charges.

When special services are reported with a basic service, the special service charges will be denied and payment will be made only for the basic service.

In addition, when these special services codes are reported independently they are not eligible for reimbursement as they do not represent separately identifiable services, but rather adjunctive services or the circumstances during which a basic service was rendered.

The "After Hours" procedure codes will not be reimbursed, regardless of the presence of Modifier 25 on the claim line. Modifier 25 should not be appended to an Evaluation and Management (E/M) service when billed with codes 99050, 99051, 99053, 99056, 99058 and 99060 as these codes do not describe separately identifiable services. See more information below on modifier 25.

Modifiers 59, XE, XP, XS and XU

CMS NCCI edits indicate when the presence of an override modifier is permitted to bypass code combination logic, and to allow separate reimbursement for both the combination code and the component code. When NCCI indicates code combinations that are never allowed separate reimbursement for both procedures, our reimbursement will be limited to the allowance of the higher paying procedure of the code combination. In these instances, Modifiers 59, XE, XP, XS and XU will not be allowed to override the code combination. This involves claims for the same patient, same date of service and the same provider specialty.

Modifier 25

Physical Medicine & Manipulation Evaluations:

Manipulation includes a pre-manipulation assessment. Time-based physical medicine services also include the time required to perform all aspects of the service, including pre-, intra-, and post-service work. Therefore, a separate Evaluation and Management (E/M) service must be medically necessary and be reported at an appropriate coding level. A separate E/M service should not be routinely reported with manipulation, therapy evaluation or time-based physical medicine services. This means that a separate Evaluation and Management (E/M) service should only be considered for payment in the following circumstances:

- Initial examination of a new patient or condition; **or**
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- Acute exacerbation of symptoms or a significant change in the patient's condition; **or**

- Distinctly different indications, which are separately identifiable and unrelated to the manipulation

Modifier "25" for the circumstances described above may be reported with medical care (e.g. consultations, E/M visits to identify it as significant and separately identifiable from the other service(s) provided on the same day. When modifier "25" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Modifier 25 exceptions:

Per Medical Policy Y-9, manipulation and physical medicine services inherently include an assessment with clinical criteria documented when a separate Evaluation and Management (E/M) service could be paid under defined circumstances by reporting the 25 modifier. Please note the following exceptions:

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Note: For purposes of a written appeal with medical records, medical decision making will be used as one of the two criteria used to score the level of visit (99214/99215) reported.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Y-1: Physical Medicine
- Commercial Policy Y-2: Occupational Therapy (OT)
- Commercial Policy Y-9: Manipulation Services

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-014: Multiple Surgical Procedures

POLICY UPDATE HISTORY INFORMATION:

02/2017	Implementation
09/2020	Note added for after hours care

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-009
Subject:	Modifiers 25, 59, XE, XP, XS and XU
Effective Date:	February 13, 2017 **End Date:**
Issue Date:	July 9, 2018
Source:	Reimbursement Policy

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

PURPOSE:

This policy addresses coverage guidelines for services considered adjunctive to a basic service and systems logic that enforces code combinations when Modifiers 25, 59, XE, XP, XS or XU are present on the claim based on CMS NCCI and/or Highmark direction.

After Hours Codes

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The "After Hours" procedure codes will not be reimbursed, regardless of the presence of Modifier 25 on the claim line. Modifier 25 should not be appended to an Evaluation and Management (E/M) service when billed with codes 99050, 99051, 99053, 99056, 99058 and 99060 as these codes do not describe separately identifiable services. See more information below on modifier 25.

Modifiers 59, XE, XP, XS and XU

CMS NCCI edits indicate when the presence of an override modifier is permitted to bypass code combination logic, and to allow separate reimbursement for both the combination code and the component code. When NCCI indicates code combinations that are never allowed separate reimbursement for both procedures, our reimbursement will be limited to the allowance of the higher paying procedure of the code combination. In these instances, Modifiers 59, XE, XP, XS and XU will not be allowed to override the code combination. This involves claims for the same patient, same date of service and the same provider specialty.

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Note: For purposes of a written appeal with medical records, medical decision making will be used as one of the two criteria used to score the level of visit (99214/99215) reported.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Y-1: Physical Medicine
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- Commercial Policy Y-9: Manipulation Services

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-014: Multiple Surgical Procedures

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-009		
Subject:	Modifiers 25, 59, XE, XP, XS and XU		
Effective Date:	February 13, 2017	**End Date:**	
Issue Date:	June 24, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

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PURPOSE:

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REIMBURSEMENT GUIDELINES:

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Modifier 25 exceptions:

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Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 modifier on the same day as chiropractic manipulative treatment (98940-98943) or osteopathic manipulative treatment (98925-98929) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Moderate to high level of complexity evaluation & management codes 99214/99215 when reported with a 25 modifier on the same day as physical therapy, occupational therapy, or athletic training evaluation codes (97161-97172) for the same patient, by the same provider, are not eligible for reimbursement. A participating or network provider cannot bill the member.

Note: For purposes of a written appeal with medical records, medical decision making will be used as one of the two criteria used to score the level of visit (99214/99215) reported.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Y-1: Physical Medicine
- Commercial Policy Y-2: Occupational Therapy (OT)
- Commercial Policy Y-9: Manipulation Services

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