PCHP Reimbursement Policy		
Topic: National Correct Coding – PTP Edits	Policy Number: PCHP.RI.012	Policy Section: Coding
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

NCCI Procedure-to-Procedure (PTP) edits are code pair edits that prevent improper payment when certain codes are submitted together.

CMS defines modifiers that may be used under appropriate clinical circumstances to bypass certain NCCI PTP edits.

Those modifiers are:

• Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI

• Global surgery modifiers: 24, 25, 57, 58, 78, 79

• Other modifiers: 27, 59, 91, XE, XS, XP, XU

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier.

• A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use.

• Appending a modifier to a code indicates records are available for review that support the modifiers use.

NCCI PTP-associated modifiers must only be used when appropriate.

Each NCCI PTP edit has an assigned modifier indicator.

• A modifier indicator of “0” indicates that NCCI-associated modifiers cannot be used to bypass the edit.

• A modifier indicator of “1” indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.

If Texas Medicaid imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicaid restrictions are fulfilled.

When clinically appropriate, an NCCI bypass modifier appended to the service that would have denied will result in a bypass of the PTP edit. For Medicaid bundling edits, if both codes in the edit pair have the same anatomic modifier and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is not bypassed.

References:

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative, National Uniform Billing Committee (NUBC)

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025