# Payment Policy: CMS Correct Coding Initiative: Unbundling Edits

Reference Number: LA.PP.031 Coding Implications
Last Review Date: 07/2026 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

**Policy Overview**
Louisiana Healthcare Connection administers unbundling edits based on the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI). These edits are further defined as procedure-to-procedure (PTP) code pair edits. The health plan administers these edits for professional and outpatient facility claims.

CMS developed the NCCI to promote national correct coding principles and facilitate correct provider reimbursement for medical services performed on patients. The NCCI edit reimbursement methodologies dictate that when two related procedure codes are billed for the same member, by the same provider and on the same date of service, only the most comprehensive of those codes is reimbursable. Therefore, physicians should not report multiple CPT codes when a single, more comprehensive code represents all services performed.

CMS organizes PTP code pairs into column 1 and column 2 pairs. Column 2 code represents the code that should not have been billed. Column 1 code is the more comprehensive code. This file also contains mutually exclusive code pairs. Mutually exclusive procedures are two procedures that could not have been performed during the same patient encounter because of anatomic, temporal or gender considerations.

NCCI edit reimbursement methodologies are based on correct coding principles established by the American Medical Association (AMA) CPT manual, national and local policies, public-domain specialty society groups, current medical practice and etc.

The CMS NCCI edit tables are updated on an quarterly basis and loaded on the CMS website listed below:
https://www.cms.gov/outreach-and-education/mln/educational-tools/mln9018659-how-to-use-the-medicaid-ncci/ncci-medicaid/chapter-4_filtering-the-ncci-data-tables/

**Application**
There are three (3) claim types that apply to NCCI PTP edits:

- Professional
- Outpatient Hospital
- Durable Medical Equipment (DME)

**Policy Description**
Modifier Use
Specific modifiers may be used to indicate that a clinical circumstance made reporting of the two codes appropriate. The patient's clinical situation must support use of the modifier. Providers should not use modifiers solely to bypass edits.

Each NCCI PTP edit is assigned a specific modifier indicator. Based on the indicator assigned, the provider 1) may not use a modifier to override the edits, 2) a modifier may be used under appropriate clinical circumstances, or 3) the edit has been deleted and the modifier is no longer appropriate

**Modifier Indicators**

| CMS NCCI Modifier Indicators | Description |
|---|---|
| 0 | Modifiers may not be used to override edits for the particular code pair scenario (No Modifier Allowed) |
| 1 | Modifier may be used (with appropriate clinical documentation) to override the edit (Modifier Allowed) |
| 9 | Procedure-to-procedure code edit has been deleted and modifier is no longer appropriate for use (Modifier Not Applicable) |

When a provider correctly appends 1 of these modifiers to a HCPCS/CPT code that is 1 of the codes in a PTP edit with a CCMI of 1, the PTP edit must be bypassed. PTP-associated modifiers are 24, 25, 27, 57, 58, 59, 78, 79, 91, E1 – E4, F1 – F9, FA, LC, LD, LM, LT, RC, RI, RT, T1 – T9, TA, XE, XP, XS, and XU. (Modifiers XE, XP, XS, and XU are valid for claims with dates of service on or after January 1, 2015.)

You may report modifier 59 or XS with either the Column 1 or Column 2 code if you did the procedures at different anatomic sites on the same side of the body and a specific anatomic modifier isn't applicable. If you did the procedures on different sides of the body, use modifiers RT and LT or another pair of anatomic modifiers. Don't use modifier 59 or XS.

Using modifier 59 or XS is appropriate for different anatomic sites during the same encounter only when procedures (that aren't ordinarily performed or encountered on the same day) are performed on different organs or different anatomic regions, or in limited situations, on different, non-contiguous lesions in different anatomic regions of the same organ.

- *Anatomical 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.
- *Additional Modifiers*
  -27, -59, -91, -XE, -XS, -XP, -XU

**Reimbursement**

The code editing software analyzes professional, outpatient hospital, and DME claims adherence to correct coding principles. The software's logic contains the CMS NCCI column 1/column 2 tables and will reference these tables to determine when multiple procedure codes were billed instead of a single, more comprehensive code. When this occurs, these services will be denied.

The Health Plan will deny all claims billed with an NCCI procedure-to-procedure procedure code combination.

**Documentation Requirements**
Below are some examples of required documentation or circumstances for use of certain modifiers:

*Modifier 59, Distinct Procedural Service*

- The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated – Modifier -59
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
    - To avoid incorrect denials, providers should assign to the claim all applicable diagnosis and procedure codes and use all applicable anatomical modifiers designating which areas of the body were treated – Modifier -59
- Claim history indicates a separate patient encounter – Modifier -59

*Modifier 25, Significant, separately identifiable Evaluation and Management (E/M) service by the same physician or other qualified health care professional on the same date of a procedure or other service.*

- The E/M service is the first time the provider has seen the patient or evaluated a major condition – Modifier -25
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed – Modifier -25
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services – Modifier -25
- The provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required an E/M service to determine the patient's need – Modifier -25

*Modifier 58, Staged or related procedure or service by the same physician during the postoperative period*

- Staged or related procedures performed by the same physician – Modifier -58
- Documented as more extensive and going beyond the original procedure
- Therapy following a diagnostic surgical procedure

Providers who do not adhere to the requirements above may be subject to a post payment medical record review and payment recoupment

**Coding and Modifier Information**

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT/HCPCS Code | Descriptor |
|---|---|
| NA | NA |

| Modifier | Descriptor |
|---|---|
| NA | NA |

| ICD-10 Codes | Descriptor |
|---|---|
| NA | NA |

**Definitions**

1. *HealthCare Common Procedure Coding System* (HCPCS), Level I Modifiers: Also known as CPT modifiers consisting of two numeric digits. These modifiers are in the range of 22-99. The list is updated annually by the AMA.
2. *HealthCare Common Procedure Coding System* (HCPCS), Level II Modifiers: Also known as the HCPCS modifiers and consist of two alpha-numeric characters. These modifiers are in the range of AA-VP. The list is updated annually by the CMS.
3. *Modifier*: Two digit numeric or alpha-numeric descriptor that is used by providers to indicate that a service or procedure has been altered by a specific circumstance, but the procedure code and definition is unchanged.
4. *Modifiers Affecting Payment*: Modifiers which impact how a claim or claim line will be reimbursed.
5. *Patient Encounter:* An interaction between a health care provider and a patient.
6. *CMS NCCI:* Centers for Medicare and Medicaid Services, National Correct Coding Initiative

**Related Documents or Resources**

1. *LA.PP.020 Distinct Procedural Modifiers: XE, XS, XP and XU*
2. *LA.PP.014 Distinct Procedural Services: Modifier 59*
3. *The Medicaid National Correct Coding Initiative*

**References**

1 *Current Procedural Terminology (CPT®)*, 2026
2 *HCPCS Level II*, 2026

3 https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual
4 https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html
5 https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf
6 2025 Medicaid NCCI Technical Guidance Manual

| Revision History | Revision Date | Approval Date | Effective Date |
|---|---|---|---|
| Converted corporate to local policy. | 08/15/20 | | |
| Annual Review;<br>Updated dates and links in the reference section from 2019 to 2021<br>Removed clinical and added payment policy in "Important Reminder" section | 08/30/22 | | |
| Annual Review; reference section updated | 7/19/23 | 9/13/23 | |
| Annual review; Remove prepayment clinical review verbiage and added a statement, "providers may be subject to post payment review;" dates updated, references reviewed, and links added for the references. | 8/20/24 | 11/20/24 | 12/20/24 |
| Annual review: added quarterly in place of annual, in the application section, removed provider and added claim. Added appropriate and inappropriate use of modifier 59 and XS, the 3 modifier description under documentation requirements. Updated links and dates | 7/25 | 12/1/25 | 12/31/25 |
| Annual review; no changes | 7/26 | 7/28/26 | |

**Important Reminder**
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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