Professional/Technical Components (Modifiers 26, TC)

Reimbursement Policy ID: RPC.0048.5400

Recent review date: 02/2024

Next review date: 11/2025

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

AmeriHealth Caritas District of Columbia reimbursement guidelines described in this policy apply to diagnostic laboratory and radiology codes designated by the Centers for Medicare & Medicaid Services (CMS) as comprised of both a professional component (PC) and a technical component (TC) that together constitute the "global" service.

Exceptions

Professional and technical service components reported by a hospital or other facility on a CMS-1450 claim form are excluded from this policy.

Reimbursement Guidelines

AmeriHealth Caritas District of Columbia determines eligibility for separate reimbursement of the professional and technical components of CPT and HCPCS procedure codes using the PC/TC Indicator from the CMS Medicare Physician Fee Schedule (MPFS). Procedure codes from the MPFS with Indicator 1 are comprised of a technical and professional component which together constitute the global service. The professional and technical components of these procedures may be reimbursed separately when reported with the correct modifier indicating the applicable service component. Providers must append an appropriate modifier corresponding to either the professional (modifier 26) or technical service (modifier TC) component of these procedures to receive separate reimbursement. Procedure codes with PC/TC Indicator ≠ 1 are not reimbursable by AmeriHealth Caritas District of Columbia when reported with modifiers for professional or technical service components.

PC/TC Indicator	Description	PC/TC Reimbursement
0	Represents physician services only.	Not applicable.
1	Diagnostic laboratory or radiology test.	Applicable with appropriate modifier.
2	PC only.	Not applicable
3	TC only.	Not applicable.
4	Global service only.	Not applicable
5	Incident to codes.	Not applicable.
6	Physician interpretation of laboratory test.	Not applicable.
7	Physical therapy service for which no payment is made.	Not applicable.
8	Code for physician interpretation.	Not applicable.
9	PC/TC concept does not apply.	Not applicable.

Definitions

Global service

Global Services include a professional and a technical component. When providers bill a global service, they assert that the same physician or other qualified health care professional provided the supervision, interpretation, and report of the professional services, as well as the technician, equipment, and facility needed to perform the procedure. Global services are identified by reporting the appropriate procedure code with no modifier(s) indicating either the professional or technical components of that procedure.

Professional component

The portion of a billed procedure encompassing only the professional services personally rendered and documented by the billing provider, correctly reported either by appending the appropriate modifier to the global (i.e., complete) procedure code, or with the corresponding stand-alone code describing the professional constituent(s) of the applicable diagnostic test.

Technical component

The portion of a billed procedure encompassing the use of technical staff, equipment, facility, and related infrastructure employed in the performance of that procedure, is correctly reported either by appending the appropriate modifier to the global (i.e., complete) procedure code, or with the corresponding stand-alone code describing the technical constituent(s) of the applicable diagnostic test.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. Centers for Medicare & Medicaid Services (CMS) PFS and Relative File Values, https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files
IV. The National Correct Coding Initiative (NCCI)
V. District of Columbia Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
08/2023	Policy implemented by AmeriHealth Caritas District of Columbia removed from Policy History section
01/2023	Template revised: • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added