

Policy Name	Professional and Technical Components
Summary	This policy describes reimbursement for codes with professional and technical components of a global procedure code.
Policy Statement	<p>A global procedure contains both professional and technical components:</p> <ul style="list-style-type: none"> • The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code. • The technical component (TC) represents the cost of the equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code. • A global service includes both professional and technical components. The global service is identified by reporting the eligible code without modifier 26 or TC. • A standalone procedure code describes selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, (b) the technical component of the test only and (c) the global test only. Modifiers 26 and TC cannot be used with these codes. <p>Medica uses the Center for Medicare and Medicaid Services (CMS) Professional Component/Technical Component (PC/TC) indicators in the National Physician Fee Schedule (NPFS) Relative Value File to determine whether a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code is eligible for separate reimbursement for professional and technical services.</p> <p>The NPFS Relative Value File containing the status indicator assignments is updated quarterly and can be located on the following CMS website:</p> <p>CMS Physician Fee Schedule Relative Value Files</p> <p>Reimbursement will be allowed for the professional and technical components or for the global procedure but not for both with the exception of certain laboratory services codes with a status indicator of 6. Medica will reimburse the professional component and the global code by the same or different physician or healthcare professional for status indicator 6 codes only. Modifier TC cannot be used with these codes.</p> <p>Reimbursement of the professional component, technical component and the global code will also be based on the physician specialty and the CMS place of service (POS) code submitted on the claim form. The place of service definitions</p>

are described in the CMS *Place of Service Codes for Professional Claims* database as described below:

CMS POS

The professional component represents the supervision and interpretation of a procedure that is furnished to an individual patient which results in a written narrative report included in the patient's medical record. An interpretation and report should address the findings, relevant clinical issues, and comparative data (when available). Billing for the professional component based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. The review is already included in the evaluation and management (E/M) payment. For example, a notation in the medical records stating "EKG-normal" or "Chest x-ray normal" would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code.

For services that are provided in a facility POS 19, 21, 22, 23, 26, 34, 51, 52, 56, or 61, and that are subject to the professional/technical concept or that have both professional and technical components according to the CMS PC/TC indicators list, Medica will reimburse the interpreting physician or other health care professional only the professional component as the facility is reimbursed for the technical component of the service. To be considered for professional component reimbursement, a service or procedure must have a:

- CMS PC/TC Indicator 1, and must be reported with modifier 26;
- CMS PC/TC Indicator 2 (professional component only codes), and must be reported without modifier 26 or TC; or
- CMS PC/TC Indicator 6 (laboratory physician interpretation codes) and must be reported with modifier 26.

Consistent with CMS, Medica will not allow reimbursement to physicians and other healthcare professionals for "Incident To" codes identified with a CMS PC/TC indicator 5 when reported in a facility place of service (POS 19, 21, 22, 23, 24, 26, 34, 51, 52, 56, or 61) regardless of whether a modifier is reported with the code. CPT coding guidelines specify that these codes are not intended to be reported by a physician in a facility setting. In addition, CPT code 96110 is not eligible for reimbursement when reported in a facility place of service.

For services that are provided in a facility POS 55 and 57 and are identified with a CMS PC/TC indicator of 1 (billed with modifier TC or submitted globally) 4 and 5 will not be reimbursed by Medica.

For Clinical Laboratory Interpretation Services provided in a facility setting, Medica will reimburse the pathologist or independent laboratory for clinical laboratory codes billed with modifier 26, as these services result in a written narrative report of results and analysis by the physician. Medica follows CMS PC/TC policy indicators in determining which services qualify for reimbursement of modifier 26:

- PC/TC indicator 1: Diagnostic Tests PC/TC indicator 6: Laboratory Physician Interpretation Codes
- PC/TC indicator 8: Physician Interpretation Codes

Medica will not reimburse a professional component (modifier 26) when a diagnostic laboratory service is provided either manually or with automated equipment, as these codes are not subject to the professional and technical concept.

CPT or HCPCS procedure codes with CMS PC/TC indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with modifiers 26 and TC.

Note: In alignment with CMS, Medica will not reimburse CPT code 85060 (PC/TC indicator 8) when reported by a physician or other health care professional with a CMS POS code other than inpatient hospital (POS 21).

Definitions

Modifier 26 – Professional Component. Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Modifier TC – Technical Component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

Code Lists

[Professional/Technical Split Percentages Code List](#)

[PC/TC Status Indicator 1 Code List](#)

[PC/TC Status Indicator 2 Code List](#)

[PC/TC Status Indicator 3 Code List](#)

[PC/TC Status Indicator 4 Code List](#)

[PC/TC Status Indicator 5 Code List](#)

[PC/TC Status Indicator 6 Code List](#)

Resources

- Centers for Medicare and Medicaid Services (CMS)
- *Current Procedural Terminology* (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- National Physician Fee Schedule (NPFS)

Effective Date

05/01/1999

Revision Updates

04/29/2020 Code list update
01/01/2020 Code list update
01/01/2019 Code list update
03/08/2018 Place of Service (POS) update
01/01/2018 Code list update