

cmi_051715

Title	Modifiers 26 and TC-Professional & Technical Components		
Number	CP.PP.151.v2.9		
Last Approval Date	05/12/26	Original Effective Date	01/01/05
Cross Reference	<ul style="list-style-type: none"> • <i>Multiple Diagnostic Imaging Reductions</i> • <i>Multiple Diagnostic Cardiovascular Services Reductions</i> • <i>Multiple Diagnostic Ophthalmology Services Reductions</i> 		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the Plan's **professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes the professional or technical component of a service reported separately that are submitted on a professional claim.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Definitions	<p><u>Professional Component:</u> The professional component of a service represents when a physician or other qualified healthcare professional renders only the professional portion of a global service. It represents the supervision, interpretation, and written report of an applicable procedure provided by the physician or other qualified healthcare professional. When rendered by the physician or other qualified healthcare professional, the CPT or HCPCS code is appended with modifier 26.</p> <p><u>Technical Component:</u> The technical component of a service incorporates the services of the technician performing a procedure, all related equipment, supplies, and institutional charges related to performing the applicable procedure. These services are provided by an institution or a facility and not separately billable by physicians. The CPT or HCPCS procedure code is appended with modifier TC by the entity that provided the testing.</p> <p><u>Global Service:</u> A global service represents BOTH the professional services rendered and the technical services associated with providing the procedure. BOTH the professional and technical components of an applicable procedure are rendered by the same provider. Modifiers 26 and TC are NOT appended to a global service code.</p> <p><u>Stand-Alone Procedure Code:</u> Stand-Alone codes are those that represent a procedure whose code description describes ONLY a professional component of a test or describes ONLY the technical component of a test or describes ONLY the global test. Modifier 26 and TC cannot be billed with these codes.</p>

<p>Policy</p>	<p>The Plan recognizes the professional and technical components of a service when the most current Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule (NPFS) identifies the applicable diagnostic service or procedure code as having separate professional and technical components.</p> <p>For diagnostic service or procedure services reference the NPFS relative value file under the Professional Component/Technical Component (PC/TC) Indicator column to identify when to:</p> <ul style="list-style-type: none"> • Bill modifier 26 for the <i>professional component</i> • Bill modifier TC for the <i>technical component</i> • Bill without a modifier when the global service is provided <p>On the NPFS file, the plan recognizes procedures assigned a PC/TC indicator of 1 or 6 as appropriate to be billed with modifier 26 to represent the professional component of the services, and a PC/TC indicator of 1 with modifier TC to represent the technical component of a service.:</p> <ul style="list-style-type: none"> • 1 - Diagnostic tests for Radiology Services – identifies codes that describe diagnostic tests; these codes have BOTH a professional and technical component. Modifiers 26 and TC can be used. • 6 – Laboratory Physician Interpretation Codes – identifies clinical laboratory codes for which a separate payment for interpretations by laboratory physicians may be made; modifier TC cannot be used with these codes. <p>All other PC/TC indicators represent codes that are defined by code description as either technical only, professional only, global only, or the PC/TC concept is not applicable and are not appropriate when billed with modifier 26 or modifier TC (see Codes/Coding Guideline section).</p> <p>If a CPT or HCPCS code is not listed in the NPFS as having a professional/technical split, it will not be reimbursed when billed with modifier 26 or TC.</p> <p>Codes that have both professional and technical components are most commonly found in the Radiology, Pathology and Laboratory, and Medicine sections of the CPT codebook.</p> <p>Multiple diagnostic radiology procedure reductions will be applied to the technical component (TC) only when multiple applicable imaging services are performed on the same patient by the same physician or other qualified healthcare professional at the same session.</p>
<p>Codes/Coding Guidelines</p>	<p>The Plan uses the CMS NPFS (PC/TC) indicators which are defined as follows:</p> <ul style="list-style-type: none"> • 0 –Physician Service Codes: physician services; modifier 26 and TC cannot be used • 1 - Diagnostic tests for Radiology Services: identifies codes that describe diagnostic tests; these codes have BOTH a professional and technical component. Modifiers 26 and TC can be used • 2 – Professional Component Only Codes: stand-alone codes that describe physician work for the code and for which there is a separate technical component code to represent the technical portion of the code; modifier 26 and TC cannot be used

	<ul style="list-style-type: none"> • 3 – Technical Component Only Codes: stand-alone codes that describe the technical component of a code and for which there is a separate professional component code; modifier 26 and TC cannot be used • 4 – Global Test Only Codes: stand-alone codes that describe procedures which already include the professional component and technical components in the single code; modifier 26 and TC cannot be used • 5 – Incident To Codes: services which are incident to a physician’s service when provided by auxiliary personnel employed by the physician and working under their direct personal supervision; modifier 26 and TC cannot be used • 6 – Laboratory Physician Interpretation Codes: identifies clinical laboratory codes for which a separate payment for interpretations by laboratory physicians may be made; modifier TC cannot be used • 7 – Physical therapy service for which payment may not be made: services rendered by an independently practicing physical or occupational therapist • 8 – Physician interpretation codes: currently applies to only one smear lab test; modifier TC cannot be used • 9 –Concept does not apply: modifier 26 and TC cannot be used <p>The NPFS file is updated quarterly and can be located using this link. Choose the appropriate quarter for the most accurate information based on the date of service.</p> <p>Modifier 26 and TC are not appropriate when appended to an E&M code and will be denied reimbursement.</p> <p>Modifiers 26 and TC applied to a stand-alone code is not appropriate and will be denied reimbursement.</p>
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined by the plan.
Exceptions	Exceptions to the policy may be made where a provider or employer group contract dictates otherwise.
Laws, Regulations & Standards	N/A
References	<ul style="list-style-type: none"> • Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) • American Medical Association’s Current Procedural Terminology (AMA/CPT) codebook • Center for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II codes

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	05/12/26; 05/05/25; 06/12/24; 07/07/23; 08/18/22; 09/22/21; 10/06/20; 10/30/19; 07/12/19; 08/09/18; 10/19/17; 10/19/16; 10/25/15; 10/26/14; 11/03/13; 11/05/12; 11/04/11; 07/05/11; 07/04/10; 02/12/10; 03/24/09; 12/02/08; 07/21/08; 06/09/07; 05/05/06; 08/29/05; 07/30/04
Version History	08/09/18 Annual Review; no changes

	07/12/19	Clarified the description of the “all other PC/TC” indicators in the 4 th paragraph
	10/30/19	<ul style="list-style-type: none"> • Added new section DEFINITIONS and included a statement on Professional Component, Technical Components, Global Service and Stand-Alone Procedure Codes that are discussed in the POLICY section • In the POLICY section: <ul style="list-style-type: none"> ○ 1st Paragraph: Provided additional information as to “what’ the professional component includes ○ 2nd paragraph: Provided additional information of the Professional/Technical split as well as a reference to global; clarified those codes not eligible for reimbursement ○ 3rd paragraph: Added location as to which codes this PC/TC split apply to ○ 4th paragraph: Expanded the description of the PC/TC Indicator flags • Added new section CODES/CODING GUIDELINES discussing ALL of the PC/TC indicator flags, identifying which CAN/CANNOT be billed with 26/TC modifiers; added statements on inappropriate use of these modifiers
	10/06/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms; Inserted PC/TC Indicator Flags 1 and 6 into the Codes/Coding Guideline section
	09/22/21	Annual review; no changes
	08/18/22	Annual review, no changes
	07/07/23	Annual review; no changes
	06/12/24	Annual review; no changes
	05/05/25	<ul style="list-style-type: none"> • Incorporated information from the “Modifier TC” Payment Policy into this policy as follows: <ul style="list-style-type: none"> ○ Added modifier TC to title of policy. ○ Added technical component to the purpose ○ Added multiple diagnostic imaging, cardiovascular, and ophthalmology policies to the cross-reference section. ○ In the policy section: <ul style="list-style-type: none"> ▪ Added TC modifier recognition details in second paragraph ▪ Added modifier TC status indicator details ▪ Added modifier TC reimbursement details • Archived the Modifier TC policy effective 5/5/2025
	05/12/26	Clarified the description of the NPFS indicator details for modifier 26 and TC details in the 1 st , 2 nd , and 3 rd paragraph of the policy section.