PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051715

Title	**Modifier 26-Professional Component**		
Number	**CP.PP.151.v2.7**		
Last Approval Date	06/11/24	**Original Effective Date**	01/01/05
Replaces	N/A		
Cross Reference	*Modifier TC – Technical Component*		

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 component of a service reported separately that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.
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	**Professional Component**: 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. **Technical Component**: 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. **Global Service:** 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. **Stand-Alone Procedure Code**: 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.

Policy	The Plan recognizes modifier 26 to indicate the professional component only of a diagnostic service or procedure. The professional component includes supervision, interpretation, and a written report of the results/outcome of the applicable procedure rendered to a patient. These professional services are identified by appending modifier 26 to the procedure code even if the provider did not perform the test personally. The Plan uses the most current version of the Center for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value file to identify those procedure codes which have an appropriate Professional/Technical split. These codes are to be billed with modifier 26 (Professional Component), modifier TC (Technical Component) or no modifier if the global service was rendered. This Professional/Technical designation is found in the Professional Component/Technical Component (PC/TC) Indicator column of the NPFS Relative Value File. CPT or HCPCS codes that are not identified in the NPFS as having a professional/technical component split will not be eligible for reimbursement when billed with either the professional or technical modifiers. Procedure codes which include professional and technical components can be found in the Radiology, Pathology and Laboratory, and Medicine sections of the CPT Codebook. 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: • **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 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). Reimbursement for procedures appended with modifier 26 will be adjusted to reflect only the professional component of the service. Procedure code modifier combinations that are not considered appropriate will be denied.

Codes/Coding Guidelines	The Plan uses the CMS NPFS (PC/TC) indicators which state as follows: • **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 • **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 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. Modifier 26 and TC are not appropriate when appended to an E&M code and will be denied reimbursement. Modifiers 26 and TC applied to a stand-alone code is not appropriate and will be denied reimbursement.
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, performance guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions Laws, Regulations & Standards	None

References	• 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	06/11/24; 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 4th paragraph
	10/30/19	• 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: o 1st Paragraph: Provided additional information as to "what' the professional component includes o 2nd paragraph: Provided additional information of the Professional/Technical split as well as a reference to global; clarified those codes not eligible for reimbursement o 3rd paragraph: Added location as to which codes this PC/TC split apply to o 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
	06/11/24	Annual review; no changes