Commercial Reimbursement Policy

Subject: **Modifier 26 and TC: Professional and Technical Component - Professional**	
Policy Number: **C-20004**	Policy Section: **Coding**
Last Approval Date: **09/15/2020**	Effective Date: **09/15/2020**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross (Anthem) benefit plan. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating professionals and facilities as indicated.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or state contract language, or state, federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 or Modifier TC in the following manner

Professional Component (Modifier 26)

The professional component is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service.. When reported separately, the professional component is denoted by adding Modifier 26 to the applicable procedure code.

Technical Component (Modifier TC)

When reported separately, the technical component is denoted by adding Modifier TC to the applicable procedure code. Services or procedures billed by a physician or other qualified health care professional that are performed in a facility as defined in Exhibit A below, will not be reimbursed for the global procedure or the technical component (Modifier TC).

Only the facility may be reimbursed for the technical component of the service or procedure.

The physician or other qualified health care professional may be reimbursed only for the professional component (Modifier 26) of the service or procedure and, if applicable, should make an arrangement with the facility for reimbursement to perform any technical components of a service or procedure.

Portable x-ray suppliers should bill **only** for the technical component by appending Modifier TC.

Global Procedure

In the absence of Modifier TC and Modifier 26, we will allow reimbursement of the global procedure if the same physician or other qualified health care professional performed both the professional component and technical

component of that service. In addition, when one provider reports a global procedure and a different provider reports the same procedure with a professional (26) or technical (TC) component modifier for the same patient on the same date of service, the first charge approved by the Health Plan will be eligible for reimbursement and subsequent charges processed will be considered duplicate services and will not be eligible for separate reimbursement.

Nonreimburseable

The Health Plan does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code.
- There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test.

The Health Plans reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC. The Health Plan may request additional documentation or notify the provider of additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, we may recoup or recover monies previously paid on the claim, as the provider failed to submit required documentation for post-payment review.

Related Coding

Standard correct coding applies.

Policy History

09/15/2020	Initial approval and effective date **09/05/2020**

References and Research Materials

This policy has been developed through consideration of the following:

- AMA Current Procedural Terminology (CPT®) 2020 Professional
- CMS (Centers for Medicaid and Medicare Services)

Definitions

Global Procedure	Represents both the professional and technical component as a complete procedure or service. Identified by reporting the eligible procedure without Modifier 26 or TC.
Professional Component (Modifier 26)	Represents the supervision and interpretation portion of a service or procedure and the preparation of a written report. Modifier 26 denotes the professional component of a global procedure or service.
Stand-alone Code	Describes the professional component only, technical component only or global test only of a selected diagnostic test. Modifier 26 and TC should not be used with a stand-alone code.
Technical Component (Modifier TC)	Represents the technical personnel, equipment, supplies and institutional charges of a service or procedure. Modifier TC denotes the technical component of a global procedure or service.
General Reimbursement Policy Definitions	

Related Policies and Materials

• Code and Clinical Editing
• Laboratory and Venipuncture Services
• Modifier Rules

• Multiple Diagnostic Cardiovascular
• Multiple Diagnostic Imaging
• Multiple Diagnostic Ophthalmology

EXHIBIT A: Place of Service Codes for Professional Claims*

Place of Service Code(s)	Place of Service Name
19	Off Campus-Outpatient Hospital
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility

*The above list of place of service codes defines facilities within the context of this policy

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.