Commercial Reimbursement Policy

Subject: **Modifiers 26 and TC - Professional**	
Policy Number: **C-20004**	Policy Section: **Coding**
Last Approval Date: **05/22/2024**	Effective Date: **10/30/2023**

Disclaimer

These reimbursement 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 an Anthem member's 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. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. 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. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem 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 the Related Coding section below, will not be reimbursed for the global procedure or the technical component.

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 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, the Health Plan 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 or technical 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.

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

- It is reported on 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, the Health Plan may recoup or recover monies previously paid on the claim, as the provider failed to submit required documentation for post-payment review.

Related Coding

Place of Service	Description	Comments
19	Off Campus-Outpatient Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service
21	Inpatient Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service
22	On Campus-Outpatient Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service
23	Emergency Room – Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service
24	Ambulatory Surgical Center	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service
51	Inpatient Psychiatric Facility	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service
61	Comprehensive Inpatient Rehabilitation Facility	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service

Policy History

05/22/2024	Review approved: added stand-alone code statement under Nonreimbursable section
10/30/2023	Review approved and effective: updated Related Coding section comments and Definitions descriptions for modifiers 26 and TC; removed *stand-alone code* statement under Nonreimbursable section
09/15/2020	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023

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)	Professional Component. Portion of a charge for health care services that represents the physician's (or other practitioner's) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges. 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
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)	Technical component; Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional serviced. 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. 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 Guidelines - Professional
Laboratory and Venipuncture Services – Professional and Facility
Modifier Rules - Professional
Multiple Procedure Payment Reduction - Professional
Multiple Diagnostic Imaging Procedures - Professional

Use of Reimbursement Policy
State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.