Payment Policy: Professional Component: Modifier -26

Reference Number: CC.PP.027
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 11/18/2024

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Policy Overview
Certain procedure codes represent both the technical and professional component of a procedure or service.

CPT or HCPCS codes assigned a CMS PC/TC indicator of 1 are comprised of a Professional Component and a Technical Component, which together constitute the Global Service. The Professional Component (PC), supervision and interpretation, is reported with modifier -26, and the Technical Component (TC) is reported with modifier -TC.

The term "professional/technical split" is used to reference a Global Service assigned a PC/TC indicator 1 that may be "split" into a Professional and Technical Component. CPT or HCPCS codes assigned a PC/TC indicator 1 are listed in the National Physician Fee Schedule Relative Value File (RVU). Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component and Professional Component.

Medicare Physician Fee Schedule Database (MPFSDB) PC/TC Indicator	Definition
0	Physician Service Codes
1	Diagnostic Tests for Radiology Services
2	Professional Component Only Codes
3	Technical Component Only Codes
4	Global Test Only Codes
5	Incident To Codes
6	Laboratory Physician Interpretation Codes
7	Physical therapy service, for which payment may not be made
8	Physician interpretation codes
9	Not Applicable

According to CMS the professional component is defined as:

> *The PC of a service is for physician work interpreting a diagnostic test or performing a procedure and includes indirect practice and malpractice expenses related to that work. Modifier 26 is used with the billing code to indicate that the PC is being billed.*

CMS further defines the technical component as:

> *The TC is for all non-physician work, and includes administrative, personnel and capital (equipment and facility) costs, and related malpractice expenses. Modifier TC is used with the billing code to indicate that the TC is being billed.*

Modifiers 26 and TC represent distinct components of a global procedure or service. When the physician's services are reported separately, the service may be identified by appending modifier 26 to the usual procedure code. When the technical component is reported separately, modifier TC should be reported with the usual procedure code.

Although in rare cases, the physician/health care provider may own the equipment and consequently is responsible for the associated processes and expenses described above, the technical component of a procedure is typically considered an institutional charge.

That said, when a health care professional performs a procedure in an institutional setting that consists of both a technical and professional component, the provider should append only the professional component modifier (26).

Application
This policy applies to the following:

- Professional Claims
- Place of Service 21, 22, 23, 24, 26, 31, 34, 41, 42, 51,52, 53, 56 and 61
- Current claim only

Reimbursement
The health plan's code editing software evaluates professional claims when billed without modifier -26 in an institutional setting.

When this occurs, the software denies the original service line and adds a new line with modifier -26 appended to the procedure code. The added service line is recommended for payment and is highlighted below in green.

Claim Example

Claim Line	DOS	Proc Code	Description	Mod 1	Charge Amount	Allow	Deny	Pay	Ex Code
100	2/16/2016	93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	-	$412.00	$239.76	$239.76	$0.00	xo
Added Line									
200	2/16/2016	93306		**26**	$412.00	$62.34	$0.00	**$62.34**	92

This edit does not change how a provider originally billed, but instead, as a courtesy to the provider, adds a new service line with the correct, payable quantity. The original service line remains on the claim.

Reference

1. *Current Procedural Terminology (CPT®), 2025*
2. *CMS Physician Fee Schedule Relative Value Files*
   https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files
3. *CMS Medicare Claims Processing Manual Chapter 12*
   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
4. *CMS Medicare Claims Processing Manual Chapter 23*
   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Revision History	
09/01/2016	**Claims Reimbursement Edit**: removed *"The original service line remains on the claim, unchanged to the extent that the....."* And replaced with "*The original service line remains on the claim*."
05/09/2017	Converted to the new template and conducted review.
06/28/2018	Conducted annual review
09/01/2019	Conducted review
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; no major updates required
12/01/2022	Annual review completed; no major updates required
12/19/2023	Annual review completed, no major updates to the policy. Reviewed and updated dates from 2022 to 2023
02/29/2024	Annual review completed; dates updated, references reviewed, and I updated the links for the references. Added the MPFSDB PC/TC Indicators.
11/18/2024	Annual Review completed

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members.

This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.