Reimbursement Policy	
Title: Professional and Technical Components	
Policy Number: RP-P-305X	**Application:** All Medica Members
Last Reviewed: 01/14/2022	**Effective Date:** 05/01/1999
Related Policies: Contrast and Radiopharmaceutical Materials, Laboratory Services, Multiple Procedure Payment Reduction (MPPR) for Diagnostic Cardiovascular and Ophthalmology Procedures, Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging	

Disclaimer: *This reimbursement policy is intended to provide general guidance regarding Medica's policy for the services described, and does not constitute a guarantee of payment. You are responsible for submitting accurate claims. Factors affecting claims reimbursement may include, but are not limited to, state and federal laws, regulations and accreditation requirements, along with administrative services agreements, provider contracts, and benefit coverage documents. Coding methodology and industry standards are also considered in developing reimbursement policy.*

Medica routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later, and you are responsible for the information contained in the most recent online version. Medica communicates policy updates to providers via Medica's monthly e-newsletter, Medica Connections®, as well as through Medica Provider Alerts.

All content included on the provider portion of medica.com is an extension of providers' administrative requirements, which all Medica network providers are contractually obligated to follow.

Summary:

This policy describes reimbursement methodology for the professional and technical component of a Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code.

Policy Statement:

To determine if a CPT or HCPCS code is eligible for separate reimbursement for professional and technical services, Medica uses the Center for Medicare and Medicaid Services (CMS) Professional Component/Technical Component (PC/TC) indicators in the National Physician Fee Schedule (NPFS) Relative Value File. This is updated quarterly and can be located on the CMS website.

CMS Physician Fee Schedule Relative Value Files

Professional and Technical Indicators identify services that are eligible for professional, technical or global reimbursement.

- The professional component, identified by appending modifier 26 to the CPT or HCPCS code, represents the supervision and interpretation of a procedure provided by a physician or other healthcare professional.
- The technical component, identified by appending modifier TC to the CPT or HCPCS code, represents cost of equipment, supplies and personnel to perform the procedure.

- A global service, identified by reporting the eligible code without modifier 26 or TC, includes both professional and technical components.
- A standalone, PC/TC Indicator 4, CPT or HCPCS code describes select diagnostic tests for which there are associated codes that describe:
    - the professional component of the test only or
    - the technical component of the test only

  Note: Modifiers 26 and TC cannot be used with these codes.

Reimbursement will be allowed for the professional and technical components or the global service but not both, with the exception of certain laboratory services with a PC/TC status Indicator 6. In the instance of status indicator 6 codes, Medica will reimburse the professional component and the global code by the same or different physician or healthcare professional. Modifier TC cannot be used with these codes.

Reimbursement of the professional component, technical component and global code will be based on the physician specialty and the CMS place of service (POS) code reported on the claim. The place of service definitions are described in the CMS Place of Service Codes for Professional Claims database.

CMS POS

The professional component represents supervision and interpretation of a procedure furnished to a patient resulting in a written narrative report in the patient's medical record. An interpretation and report should address findings, relevant clinical issues and comparative data (when available). Billing for the professional component based on a review of the findings without a complete written report does not meet the conditions for separate payment of the service. The review is already included in the evaluation and management (E/M) payment. For example, a notation in the medical records stating "EKG-normal" or "Chest x-ray normal" would not meet the requirement of a separately payable interpretation and report, and should not be considered a review of findings payable through the E/M code.

For services provided in facility POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61, and are either subject to the professional/technical concept, or have both professional and technical components according to the CMS PC/TC Indicators list, Medica will reimburse the professional component to the interpreting physician or other health care professional only as the facility will be reimbursed for the technical component of the service. In addition, CPT code 96110 is not eligible for reimbursement when reported in a facility place of service.

To be considered for professional component reimbursement, a service or procedure must include:

- CMS PC/TC Indicator 1 and be reported with modifier 26 or
- CMS PC/TC Indicator 2 (professional component only codes) and be reported without modifier 26 or TC or
- CMS PC/TC Indicator 6 (laboratory physician interpretation codes) and be reported with modifier 26 or

- CMS PC/TC Indicator 8 (physician interpretation codes) and be reported without modifier 26

Consistent with CMS, Medica will not reimburse physicians or other healthcare professionals for *Incident To* codes, identified with a CMS PC/TC Indicator 5, when provided to hospital inpatients or patients in a hospital outpatient department. CPT coding guidelines specify that these codes are not intended to be reported by a physician in a facility setting.

In addition, services that are provided in facility POS 55 and 57 and identified with a CMS PC/TC Indicator 1 (billed with modifier TC or submitted globally), 4 or 5 will not be reimbursed by Medica.

For Clinical Laboratory Interpretation Services provided in a facility setting, Medica will reimburse the pathologist or independent laboratory for clinical laboratory codes billed with modifier 26, as these services result in a written narrative report of results and analyses by the physician. Medica follows CMS PC/TC indicators in determining which services qualify for reimbursement of modifier 26:

- CMS PC/TC indicator 1: Diagnostic Tests
- CMS PC/TC indicator 6: Laboratory Physician Interpretation Codes
- CMS PC/TC indicator 8: Physician Interpretation Codes

Medica will not reimburse a professional component when a diagnostic laboratory service is provided manually or with automated equipment as these codes are not subject to the professional and technical concept.

CPT or HCPCS codes with CMS PC/TC indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with 26 and TC modifiers.

Note: In alignment with CMS, Medica will not reimburse CPT code 85060 (PC/TC indicator 8) when reported by a physician or other health care professional unless billed with a POS 21, inpatient hospital.

Modifiers:
Modifier 26 – Professional Component. 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. **Modifier TC** – Technical Component. 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.

Code Lists:
PC/TC Status Indicator 1 Code List PC/TC Status Indicator 2 Code List PC/TC Status Indicator 3 Code List PC/TC Status Indicator 4 Code List PC/TC Status Indicator 5 Code List PC/TC Status Indicator 6 Code List

Definitions:
Global Service – A Global Service includes both a professional and technical component. The global service identifies the supervision, interpretation and report of professional and the technical services, which include the technician, equipment and the facility used in performing the procedure. **Incident To** – Services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness

Resources:
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)

Effective Date:	01/01/2022

Revision Updates:	
01/14/2022	Template and Code List Update
10/18/2021	Annual Policy Review
07/01/2021	Code List Update
04/29/2020	Code List Update
01/01/2020	Code List Update

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