

Payment Policy: Professional Component: Modifier -26

Reference Number: LA.PP.027

Product Types: ALL

Effective Date: 08/2020

Last Review Date: 08/202

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. Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component, and Professional Component.

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

Policy Description

Reimbursement

Louisiana Healthcare Connections code editing software logic will evaluate professional claims when billed without modifier -26 in an institutional setting.

When this occurs, the software denies the original service line and add 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.

Utilization

Not Applicable

Documentation Requirements

Not Applicable

Definitions

Not Applicable

Reference

1. *Current Procedural Terminology (CPT®)*, 2021
2. *Centers for Medicare and Medicaid Services, CMS Manual System* and other CMS publications and services.

Revision History	
08/15/2020	Converted corporate to local policy.
08/29/2022	Annual Review; Removed clinical and added payment policy in “Important Reminder” section Updated: date in “Reference” section from 2019 to 2021

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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 payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. 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.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____ Electronic Signature on File__

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