IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.
Reimbursement Guidelines

Procedures that are comprised of both a technical and professional component are identified on the National Medicare Physician Fee Schedule Database (MPFSDB) in Field 20 with a Professional Component (PC)/Technical Component (TC) Indicator of “1”.

It is never appropriate for the technical and professional components to be unbundled and reported separately under the same TIN number (whether on separate line items of a single claim or on separate claims). (CPT Assistant3)

When determining if the technical and professional components were performed by the “same provider” or by different providers, if both components will be billed under the same tax ID number (TIN) then both components were performed by the same provider and are not eligible to be reported as separate components. Instead the global service should be billed without modifier TC or 26.

Example:
If the x-ray equipment is jointly owned by the physicians in a clinic, then the clinic must obtain a separate TIN number in order to separately submit the technical component (TC) of the service.

If the clinic has not obtained a separate TIN (and a separate contract with Moda Health to be participating), then the global service must be billed by the interpreting clinic physician. The clinic must manage the equitable distribution of reimbursement for the technical component of the service internally through accounting and the joint ownership agreement for the shared equipment.

When the technical and professional components of a procedure are unbundled and billed to Moda Health under the same TIN, the Moda Health claims processing system will process the component procedures in a variety of ways (due to system constraints).

- Often the system will deny one component as a subset to the other component, resulting in an underpayment. In these situations, no override or bypass will be given for the edit. Moda Health requires a corrected claim with the procedure billed as a global service (without -TC or -26 modifier) for any adjustment or additional reimbursement to be considered.
- The system may rebundle the component services into the global service. If this occurs, the claim will not be adjusted to process the components on separate lines. If the components were provided by separate entities, each component must be billed under a separate TIN on separate claims, and a corrected claim set will be required.
- In some cases both components may be separately allowed, but the total allowed fee will not be any higher than if the service had been correctly billed as the global service.

Only the components that have been actually performed by the billing provider may be billed to Moda Health. If only one of the components has been performed, charges may not be submitted to Moda Health for the component that has not been performed. The instructions in CMS Transmittal
1892/CR6733 are both optional and conditional, and do not apply to claims submitted to Moda Health.

While CMS does sometimes instruct providers to re-bill the service as separate professional and technical component procedure codes, our research indicates this is specifically related to the calculation of CMS bonus payments in a health professional shortage area (HPSA), and does not apply to billing to commercial carriers such as Moda Health.

**Submitting Only the Professional Component**
- Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 1, 6, or 8 (see field 20 on the MPFSDB) will be allowed with modifier 26 appended.
- Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, or 9 will be denied when submitted with modifier 26 appended. The denial explanation code will indicate that the procedure code is inconsistent with the modifier used (N27 or 514). For billing offices using 835 electronic remittance advice files, these explanation codes are mapped to claim adjustment reason code 4.

**Submitting Only the Technical Component**
- Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 1 (see field 20 on the MPFSDB) will be allowed when modifier TC is appended.
- Procedure code with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 6, 7, 8, or 9 will be denied when submitted with modifier TC appended. The denial explanation code will indicate that the procedure code is inconsistent with the modifier used (N27 or 514). For billing offices using 835 electronic remittance advice files, these explanation codes are mapped to claim adjustment reason code 4.

**Reviewing Diagnostic Data During Evaluation and Management Services**

Per the CPT Book Evaluation and Management (E/M) Services Guidelines, reviewing and analyzing diagnostic tests and other information is part of the Medical Decision Making component of E/M services. (AMA10) Emergency room physicians, orthopedic surgeons, trauma specialists, surgeons, internists, family physicians, podiatrists and other treating physicians who routinely review pathology results, chest x-rays, EKGs, and/or other diagnostic data evaluation as an integral part of their reimbursed patient care services are not entitled to an additional reimbursement of a professional component for that review. The review and evaluation of diagnostic data is covered by the reimbursement for office visit and treatment. (AMA11) A separate, signed interpretation and report is required to support the billing of the professional component of such diagnostic tests.

**Technical Services Provided to Hospital Patients**

Moda Health applies the CMS guidelines and requirements to all claims from all lines of business which require facilities to bill for the technical component of pathology services and other diagnostic services, even when provided under arrangement or subcontracted to another provider. Moda Health will reimburse the facility for these technical services. Global payment arrangements
(e.g. APC, DRG) include reimbursement for these technical services, whether provided by the facility directly, or by a subcontracted provider.

Moda Health will deny the global code or technical component of services billed by a professional provider for services performed in a facility (e.g. place of service 21, 22, 23, etc.). The professional provider may report only the professional component (-26) to Moda Health.

The subcontracted provider with whom the hospital has an arrangement to provide any technical service must look to the facility for reimbursement for these subcontracted services.

**Background Information**

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.
Definitions

No modifier used

Unmodified CPT codes are intended to describe both the technical and professional components of a service. The professional and technical components together are referred to as the "global service." (CPT Assistant³)

Modifier 26

**Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the 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.

Global service

Unmodified CPT codes are intended to describe both the technical and professional components of a service. The professional and technical components together are referred to as the "global service." (CPT Assistant³)

Coding Guidelines

“If the technical and professional components of the service are performed by the same provider, then it is not appropriate to report the components of the service separately.” (CPT Assistant³)

When the service is furnished to a hospital outpatient or inpatient, the facility bills the technical component, which includes the cost of equipment, supplies, technician salaries, etc. (CPT Assistant³)

If the interpreting physician is not paid by the facility for services but will instead be billing the carrier separately, the physician may bill only for the professional component.

“In closing, when reporting the technical component of a procedure or service, it is important to familiarize yourself with the various reporting requirements of individual insurance companies in your area. These reporting and reimbursement policies may vary from one insurance company to another.” (CPT Assistant³)

The hospital must bill for the technical component portion of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist, or other provider. (CPT Assistant³, CMS⁷, Medicare Desk Reference for Hospitals⁸, CMS⁹)
“For services furnished to hospital outpatients or inpatients, the physician may bill only for the professional component...This requirement applies even if the service for a hospital patient is performed in a physician's office.” (CPT Assistant³)

“Effective on or after January 1, 2011, only the hospital may bill for the TC of a physician pathology service provided to an inpatient or outpatient.” (Medicare Claims Processing Manual, Laboratory Services chapter⁷)

“Hospitals must provide directly or under arrangements all services furnished to hospital outpatients. Therefore, if a specimen (e.g., tissue, blood, urine) is taken from a hospital patient, the facility or technical component (TC) of the diagnostic test must be billed by the hospital. Only in cases where the patient leaves the hospital and obtains the service elsewhere is the hospital not required to bill for the service...At the request of the industry, the implementation of this rule was delayed to allow independent laboratories and hospitals sufficient time to negotiate arrangements...through February 29, 2012.” (Medicare Desk Reference for Hospitals⁸)

Cross References
None.

References & Resources


