Scope

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

This policy applies to all provider types. While the PC/TC indicator is located on the Physician Fee Schedule, the components of the code and code definition remain the same when billed by facilities and other provider types.

Reimbursement Guidelines

A. Designating Procedure Codes With Technical and/or Professional Components

Many, but not all, procedure codes are comprised of a technical and/or professional component. The CMS Physician Fee Schedule (MPFSDB) PC/TC indicator defines whether a procedure code includes a technical component, a professional component, both the TC and PC components, or neither (when the concept does not apply). The place of service where the procedure is performed and who owns the equipment used is what determines which provider(s) and provider type(s) may bill the various components of the service.

1. 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”.

2. 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)

   a. 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 needs to 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.

b. 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.

c. Note: 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.

**B. The Professional Component Only**

1. 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.

2. Procedure codes with a PC/TC indicator of 1 may not be reported as a global service when performed in an Inpatient or Outpatient hospital or skilled nursing setting; only the professional component may be billed.

3. 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.

4. The denial explanation code will indicate that the procedure code is inconsistent with the modifier used (e.g. 514, n59, t35, t40, u13, t38, z52, z63). For billing offices using 835 electronic remittance advice files, these explanation codes are mapped to claim adjustment reason code 4.

**C. The Technical Component Only**

1. 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.

2. 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.
3. The denial explanation code will indicate that the procedure code is inconsistent with the modifier used (e.g. 514, n59, t35, t40, u13, t38, z52, z63). For billing offices using 835 electronic remittance advice files, these explanation codes are mapped to claim adjustment reason code 4.

D. Medical Direction Of Clinical Laboratory Services Automated Tests

1. Moda Health follows CMS policy for all lines of business for medical direction and supervision of automated clinical laboratory tests.
   a. Only procedure codes with a PC/TC indicator of 1, 6, or 8 may be reported with modifier 26 appended.
   b. Automated lab tests do not have a PC/TC indicator of 1, 6, or 8.
      i. These procedure codes for automated tests are assigned indicator “9” “Concept of a professional/technical component does not apply.” By this CMS is indicating these procedure codes do not have a professional component which can be reported by a physician/pathologist.
      ii. Automated lab test procedure codes are not eligible for reimbursement when submitted with modifier 26 appended. The line item will deny to provider liability.
   c. Payment to the hospital or Independent Clinical Laboratory includes payment for the pathologist’s medical direction and supervision services to ensure that the automated laboratory machines produce accurate and reliable test results. The pathologist serving as the medical director for the laboratory needs to seek payment from the hospital or independent laboratory for their medical director services.

2. CMS policy is considered to be the community standard for Commercial laboratory services as well as for Medicare and Medicaid lines of business. (13, AMA3, 15)

E. Reviewing Diagnostic Data During Evaluation and Management Services

1. 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)

2. A separate, signed interpretation and report similar to that which would be prepared by a specialist in the field is required to support the billing of the professional component of such diagnostic tests. (CMS12)

F. Technical Services Provided to Hospital Patients

1. 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.

2. 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.

3. 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.

G. PC/TC Indicator “8” Physician Interpretation Codes

PC/TC indicator “8” is defined as “...separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient...” CMS has designated place of service "21" as inpatient and it is the only recognized place of service designation when the PC/TC indicator is ‘8.’ All other place of service designations are inappropriate.

Codes, Terms, and Definitions

**Acronyms Defined**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>EOCCO</td>
<td>Eastern Oregon Coordinated Care Organization</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>MPFSDB</td>
<td>(National) Medicare Physician Fee Schedule Database (aka RVU file)</td>
</tr>
<tr>
<td>PC</td>
<td>Professional Component</td>
</tr>
<tr>
<td>RVU</td>
<td>Relative Value Unit</td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component</td>
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</table>

**Global Terms & Modifiers:**

<table>
<thead>
<tr>
<th>Modifier/Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>No modifier used</td>
<td>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 &quot;global service.&quot; (CPT Assistant³)</td>
</tr>
<tr>
<td>Modifier/Term</td>
<td>Definition</td>
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<tr>
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</tr>
<tr>
<td>Modifier 26</td>
<td><strong>Professional Component:</strong> 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.</td>
</tr>
<tr>
<td>Modifier TC</td>
<td><strong>Technical Component.</strong> 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.</td>
</tr>
<tr>
<td>Global service</td>
<td>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 &quot;global service.&quot; (CPT Assistant³)</td>
</tr>
</tbody>
</table>

**Status Indicators:**

The Medicare Physician Fee Schedule (MPFSDB) Professional Component (PC)/Technical Component (TC) (PC/TC) Indicators in use are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 &amp; TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.</td>
</tr>
<tr>
<td>1</td>
<td>Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Indicator Definition</td>
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<td>-----------</td>
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<tr>
<td>2</td>
<td>Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.</td>
</tr>
<tr>
<td>3</td>
<td>Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.</td>
</tr>
<tr>
<td>4</td>
<td>Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.</td>
</tr>
<tr>
<td>5</td>
<td>Incident to codes: This indicator identifies codes that describe services covered incident to a physician’s service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by A/B MACs (B) for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.</td>
</tr>
<tr>
<td>6</td>
<td>Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.</td>
</tr>
<tr>
<td>7</td>
<td>Private practice therapist’s service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Indicator Definition</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>8</td>
<td>Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.</td>
</tr>
<tr>
<td>9</td>
<td>Concept of a professional/technical component does not apply.</td>
</tr>
</tbody>
</table>

**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. 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.” (CPT Assistant3)

“Professional Component (PC)/Technical Component (TC) Indicator 9 = Concept of a professional/technical component does not apply.” (CMS14)

“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 Hospitals®)

Cross References


References & Resources


4. “Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment


   Hospitals. October 2012.


    http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp .

    Diagnostic Procedures, §100.1.

13. Comment: This is one instance where CMS guidelines do not agree with information from the
    College of American Pathologists Professional Relations Manual as cited by the AMA in “Technical
vs. Professional Component,“ CPT Assistant, May 1999 (CMS)³. Note, this article also concludes the discussion of this issue by stating, “In closing...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.”

Moda Health follows CMS guidelines; see RPM001 which states “In rare cases discrepancies exist between guidelines on a specific topic from two or more sources listed above. In these situations, Moda Health has sole discretion to determine which guideline to use in the development of Moda Health Reimbursement Policy.”


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.

**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.