BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Professional and Technical Components for Applicable Services

Active

Section: General Coding
Policy Number: 019
Effective Date: 07/01/24

Description

This policy addresses coding and reimbursement for professional and technical components for applicable services. This policy applies to services reported on a professional (837P) claim.

Definitions

Technical Component (TC): Refers to the facility and equipment costs of performing a study, inclusive of supplies and a technologist or technician to conduct the exam. When reported separately, it is represented by appending the modifier TC to the procedure code.

Professional Component (PC): Refers to supervision and interpretation of a procedure, which requires a written narrative report of the service provided, including results and analysis by the provider. When reported separately, it is represented by appending the 26 modifier to the procedure code.

Global Service: Represents the complete study, including both technical and professional components. It is represented by reporting the procedure code without the 26 or TC modifiers.

Standalone: Refers to 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. Modifiers 26 and TC cannot be used with these codes.

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) utilizes the Centers for Medicare and Medicaid Services (CMS) Professional/Technical Component (PC/TC) indicators and place of service (POS) codes reported on the claim to determine which procedure code/modifier combinations are valid for reimbursement. In those cases where codes are not used by CMS (e.g., codes that are non-covered, excluded, or invalid for Medicare), Blue Cross has reviewed and assigned appropriate PC/TC indicators. Combinations that are not considered valid will be denied.

The PC/TC indicators, which are found in the CMS National Physician Fee Schedule Relative Value file, identify services that are eligible for professional, technical, or global reimbursement:

PC/TC Indicator	Description	Modifiers
0	Physician Service Codes	The concept of PC/TC does not apply. Modifiers 26 and TC cannot be used with these codes.
1	Diagnostic Tests for Radiology Services	These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes.
2	Professional Component Only Codes	Stand-alone codes that describe the physician work portion of selected diagnostic tests. Modifiers 26 and TC cannot be used with these codes.
3	Technical Component Only Codes	Stand-alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests. Modifiers 26 and TC cannot be used with these codes.
4	Global Test Only Codes	Stand-alone codes that describe selected diagnostic tests 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.
5	Incident To Codes	Identifies codes that describe services covered incident to a physician's service when provided by auxiliary personnel employed by and working under physician. Modifiers 26 and TC cannot be used. Services cannot be paid when they are rendered to patients in inpatient or outpatient hospital setting.
6	Laboratory Physician Interpretation Codes	Identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Modifier TC cannot be used. Physician performing interpretations of these codes must be billed with modifier 26.
7	Physical Therapy Service	Payment may not be made.
8	Physician Interpretation Codes	For physician interpretation of an abnormal smear for hospital inpatient. No TC billing is

		recognized. The actual test is paid to the hospital.
9	Not Applicable	The concept of PC/TC does not apply.

For PC/TC eligible codes, reimbursement may be allowed for the professional and technical components or the global service, but not both, regardless of whether billed by the same or different provider, specialty, or Tax ID.

For services provided in a facility place of service that are subject to the professional/technical concept:

- Only the interpreting physician or other health care professional will be reimbursed for the professional component of the service. If a PC/TC eligible code is submitted by a physician or other health care professional without the 26 modifier, only the professional component will be reimbursed.
- Only the facility will be reimbursed for the technical component of the service. If a PC/TC eligible code is submitted by a facility without the TC modifier, only the technical component will be reimbursed.

Physician Owned and Portable Equipment
Separate payment may be made for the technical and professional components of a procedure when each is performed by different professional providers (e.g., the provider who owns the equipment reports only the technical component; the interpreting provider reports only the professional component). Each provider should report the procedure code with appropriate modifier to reflect the actual services performed (e.g., modifier 26 for professional component; modifier TC for technical component).

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	26	TC
ICD-10 Diagnosis:	N/A	
ICD-10 Procedure:	N/A	
CPT/HCPCS:	N/A	
Revenue Codes:	N/A	

Resources

Centers for Medicare and Medicaid Services (CMS) Place of Service Code Set. Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Medicare Claims Processing Manual. Chapter 13, Sections 20.1-20.2.2
National Physician Fee Schedule (NPFS) Relative Value File

Policy History

10/21/2015	Initial Committee Approval
02/24/2020	Code Update
07/27/2021	Annual Policy Review
06/27/2023	Revised
06/25/2024	Annual Policy Review