Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy’s direction and regional applicability.

PURPOSE:

Certain services (e.g., radiology tests, diagnostic medical procedures) include a distinct technical component (modifier TC), consisting of equipment and technical personnel costs. There is also a professional component (modifier 26), which represents the interpretation of test results by the professional provider/physician.

REIMBURSEMENT GUIDELINES:

Commercial

When both the technical and professional components of a procedure are performed by the same professional provider in a setting other than inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, a single charge should be reported for the total procedure.

If a “total charge” procedure is reported inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, payment to the professional provider will be limited to the interpretation or professional component (modifier 26). Any technical costs (modifier TC) incurred for a procedure performed in a facility setting are reimbursed to the facility.

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

All services must be performed and reported by eligible professional providers.

**Note:** Delaware Ambulatory Surgery Centers (ASCs) are considered outside the scope of this reimbursement policy.

**Medicare Advantage**

Payment can be made for the professional component of diagnostic services furnished by a physician to an individual patient in all settings regardless of the specialty of the physician who performs the service.

Payment can be made for the technical component of radiology services furnished to members who are not patients of any hospital, and who receive services in a physician's office, a freestanding imaging or radiation oncology center, or other setting that is not part of a hospital.

Payment cannot be made for the technical component of diagnostic services furnished to a hospital or skilled nursing facility (SNF).

**Reference:** CMS Online Manual Pub. 100-04, Chapter 13, Sections 20.1, 20.2, 20.2.1, 20.2.2

**DEFINITIONS:**

*Modifier 26 – Professional Component*

*Modifier TC – Technical Component*

**RELATED MEDICAL POLICIES:**

Refer to the following Medical Policies for additional information:

- Commercial Medical Policy: Z-27 Eligible Providers and Supervision Guidelines

**ADDITIONAL BILLING INFORMATION, REFERENCES AND GUIDELINES:**

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