	Reimbursement Policy

Subject: Modifier 26 and TC: Professional and Technical Component

Effective Date: **10/01/17**	Committee Approval Obtained: **10/26/18**	Section: **Coding**

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com/DC. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup District of Columbia, Inc. benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's District of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC unless provider, District, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the following: • The applicable fee schedule or contracted/negotiated rate • Physician specialty and the place of service code submitted with the claim

	Professional Component (Modifier 26) The professional component is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service. The professional component includes the supervision and interpretation portion of a procedure and the preparation of a written report. When reported separately, the professional component is denoted by adding Modifier 26 to the applicable procedure code. **Technical Component (Modifier TC)** The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure. When reported separately, the technical component is denoted by adding Modifier TC to the applicable procedure code. Services or procedures billed by a physician or other qualified health care professional that are performed in a facility, as defined in Exhibit A, will not be reimbursed for the global procedure or the technical component (Modifier TC). Only the facility may be reimbursed for the technical component of the service or procedure. The physician or other qualified health care professional may be reimbursed only for the professional component of the service or procedure and, if applicable, should make an arrangement with the facility for reimbursement to perform any technical components of a service or procedure. Portable X-ray suppliers should bill **only** for the technical component by appending Modifier TC. **Global Procedure** In the absence of Modifier TC and Modifier 26, we will allow reimbursement of the global procedure if the same physician or other qualified health care professional performed both the professional component and technical component of that service. **Nonreimbursable** Amerigroup does not allow reimbursement for use of Modifier 26 or Modifier TC when: • It is reported with an evaluation and management code. • There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test. Amerigroup reserves the right to perform postpayment review of claims submitted with Modifier 26 or Modifier TC. Amerigroup may request additional documentation or notify the provider of additional

	documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, Amerigroup may recoup or recover monies previously paid on the claim as the provider failed to submit required documentation for postpayment review.
History	• Biennial review approved **10/26/18**: Policy template updated • Initial approval **07/19/17** and effective date **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance • American Medical Association: Coding with Modifiers, fifth edition • Optum Learning: Understanding Modifiers, 2015 edition • "Place of Service Codes for Professional Claims." Centers for Medicare and Medicaid Services. August 6, 2015
Definitions	• **Global Procedure:** represents both the professional and technical component as a complete procedure or service; identified by reporting the eligible procedure without Modifier 26 or TC • **Professional Component (Modifier 26):** represents the supervision and interpretation portion of a service or procedure and the preparation of a written report; Modifier 26 denotes the professional component of a global procedure or service • **Standalone Code:** describes the professional component only, technical component only or global test only of a selected diagnostic test; Modifier 26 and TC should not be used with a standalone code • **Technical Component (Modifier TC):** represents the technical personnel, equipment, supplies and institutional charges of a service or procedure; Modifier TC denotes the technical component of a global procedure or service • **General Reimbursement Policy Definitions**
Related Policies	• Documentation Standards for Episodes of Care • Modifier Usage • Multiple Procedure Payment Reduction • Multiple Radiology Payment Reduction • Portable/Mobile/Handheld Radiology Services • Site of Services Payment Differential — Professional
Related Materials	• None

Exhibit A: Place of Service Codes for Professional Claims*

Place of Service Code(s)	Place of Service Name
19	Off Campus — Outpatient Hospital
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility

* The above list of place of service codes defines facilities within the context of this policy.