Payment Policy: Professional Component: Modifier -26

Reference Number: LA.PP.027
Effective Date: 08/2020 Coding Implications
Last Review Date: 045/20254 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Certain procedure codes represent both the technical and professional component of a procedure or service.

CPT or HCPCS codes assigned a CMS PC/TC Indicator of 1 are comprised of a Professional Component and a Technical Component, which together constitute the Global Service. The Professional Component (PC), supervision and interpretation, is reported with modifier 26, and the Technical Component (TC) is reported with modifier TC.

The term "professional/technical split" is used to reference a Global Service assigned a PC/TC Indicator 1 that may be "split" into a Professional and Technical Component. CPT or HCPCS codes assigned a PC/TC Indicator 1 are listed in the National Physician Fee Schedule Relative Value File. Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component, and Professional Component.

According to CMS the professional component is defined as:

> *The PC of a service is for physician work interpreting a diagnostic test or performing a procedure, and includes indirect practice and malpractice expenses related to that work. Modifier 26 is used with the billing code to indicate that the PC is being billed.*

CMS further defines the technical component as:

> *The TC is for all non-physician work, and includes administrative, personnel and capital (equipment and facility) costs, and related malpractice expenses. Modifier TC is used with the billing code to indicate that the TC is being billed.*

Modifiers 26 and TC represent distinct components of a global procedure or service. When the physician's services are reported separately, the service may be identified by appending modifier 26 to the usual procedure code. When the technical component is reported separately, modifier TC should be reported with the usual procedure code.

Although in rare cases, the physician/health care provider may own the equipment and consequently is responsible for the associated processes and expenses described above, the technical component of a procedure is typically considered an *institutional* charge.

That said, when a health care professional performs a procedure in an institutional setting that consists of both a technical and professional component, the provider should append only the professional component modifier (26).

Application
This policy applies to the following:

- Professional Claims
- Place of Service 21, 22, 23, 24, 26, 31, 34, 41, 42, 51,52, 53, 56 and 61
- Current claim only

Reimbursement
Louisiana Healthcare Connections code editing software logic will evaluate professional claims when billed without modifier -26 in an institutional setting.

When this occurs, the software denies the original service line and add a new line with modifier -26 appended to the procedure code. The added service line is recommended for payment and is highlighted below in green.

Claim Example

Claim Line	DOS	Proc Code	Description	Mod 1	Charge Amount	Allow	Deny	Pay	Ex Code
100	2/16/2016	93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	-	$412.00	$239.76	$239.76	$0.00	xo
Added Line									
200	2/16/2016	93306		26	$412.00	$62.34	$0.00	$62.34	92

This edit does not change how a provider originally billed, but instead, as a courtesy to the provider, adds a new service line with the correct, payable quantity. The original service line remains on the claim.

Reimbursement for Laboratory and Radiology Procedures

Providers shall not submit claims for both the professional component and the full service for the same patient for the same laboratory or radiology service on the same date of service.

To receive reimbursement for the full service, the provider must own or lease, and have on the premises, the necessary equipment. Reimbursement for the full service encompasses both the use of the equipment and the provider's professional service.

Certain procedures are a combination of a professional component and a technical component. When the professional component is reported separately, providers may bill the procedure code with the appropriate modifier to denote only the professional component. Louisiana Medicaid does not reimburse for the technical component separately

NOTE: Louisiana Medicaid does not reimburse technical component (TC modifier) on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.

Utilization
Not Applicable

Documentation Requirements
Not Applicable

Definitions
Not Applicable

Reference
1. *Current Procedural Terminology (CPT®)*, 2024
2. https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm
~~1.~~
3. https://ldh.la.gov/assets/medicaid/Manuals/MCO_Manual.pdf
~~2. CMS Medicare Claims Processing Manual Chapter 12 https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c12.pdf~~
~~3. CMS Medicare Claims Processing Manual Chapter 23 https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/clm104c23.pdf~~

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section Updated: date in "Reference" section from 2019 to 2021	08/29/2022	
Annual Review, update reference date	06/16/2023	9/13/2023
Annual review completed; dates updated, references reviewed, and updated the links for the references	05/2024	5/28/2024
Annual review; Added the reimbursement for labs & radiology procedures for professional components; references reviewed and updated.	04/2025	

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.