REIMBURSEMENT POLICY

Professional and Technical Components for Applicable Services

Active

Policy Number: General Coding – 019
Policy Title: Professional and Technical Components for Applicable Services
Section: General Coding
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Product: ☒Commercial ☒FEP ☐Medicare Advantage ☐Platinum Blue

Description

This policy addresses coverage and reimbursement for professional and technical components for applicable services.

Definitions

Technical Component: Refers to the facility and equipment costs of performing a study, inclusive of supplies and a technologist or technician to conduct the exam. It is represented by appending the modifier -TC to the procedure code.

Professional Component: Refers to supervision and interpretation of results from the test, which requires a written narrative report of the service provided, including results and analysis by the provider. 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.

Policy Statement

When the technical component of a procedure occurs under the direction of the same practitioner that performs the professional components of procedure 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. (Any technical costs 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 (e.g., modifier - 26 for professional component; modifier - TC for technical component).

Documentation Submission

Documentation must identify and describe the services performed. The practitioners providing the professional and technical components must also be identified.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross 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	

Cross Reference

Cross Reference: N/A

Policy History

10/21/2015	Initial Committee Approval Date
11/29/2017	Annual Policy Review
02/24/2020	Annual Policy Review
07/27/2021	Annual Policy Review