Reimbursement Policy	
Subject: **Modifier 26 and TC**	
Policy Number: **G-15004**	Policy Section: **Coding**
Last Approval Date: **10/30/2023**	Effective Date: **10/30/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **provider.wellpoint.com/wv**.****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Wellpoint covered the service for the member's 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 state 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or

requirements. Wellpoint strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Wellpoint 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, state, 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 healthcare professional renders only the professional component of a global procedure or service. When reported separately, the professional component is denoted by adding Modifier 26 to the applicable procedure code.

Technical Component (Modifier TC)

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 healthcare professional who are performed in a facility place of service as defined in the Related Coding section below, will not be reimbursed for the global procedure or the technical component.

Only the facility may be reimbursed for the technical component of the service or procedure.

The physician or other qualified healthcare 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, Wellpoint will allow reimbursement of the global procedure if the same physician or other qualified healthcare professional performed both the professional component and technical component of that service.

Nonreimbursable
Wellpoint does not allow reimbursement for use of Modifier 26 or Modifier TC when it is reported with an Evaluation and Management (E/M) code.

Wellpoint reserves the right to perform post payment review of claims submitted with Modifier 26 or Modifier TC. Wellpoint 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, Wellpoint may recoup or recover monies previously paid on the claim, as the provider failed to submit required documentation for post payment review.

Related Coding		
Place of service	**Description**	**Comments**
19	Off Campus-Outpatient Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service.
21	Inpatient Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service.
22	On Campus-Outpatient Hospital	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service.
23	Emergency Room – Hospital	Defines facilities within the context of this policy.

		The global procedure or technical component will not be reimbursed to a physician in this place of service.
24	Ambulatory Surgical Center	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service.
51	Inpatient Psychiatric Facility	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service.
61	Comprehensive Inpatient Rehabilitation Facility	Defines facilities within the context of this policy. The global procedure or technical component will not be reimbursed to a physician in this place of service.

Policy History	
10/30/2023	Review approved and effective: removed *Professional and Technical Component* from the policy title; updated comments in Related Coding section; updated Modifiers 26 and TC in Definitions section
07/13/2020	Review approved: policy language updated to remove *definitions* from the policy body; minor administrative changes
10/26/2018	Review approved: policy template updated
08/01/2016	Initial approval 08/01/2016 and effective 04/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023
- State contract

• State Medicaid

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)	Professional Component. Portion of a charge for healthcare services that represents the physician's (or other practitioner's) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges. Certain procedures are a combination of a physician or other qualified healthcare professional component and a technical component. When the physician or other qualified healthcare professional component is reported separately, the service may be identified by adding Modifier 26 to the usual procedure number.
Standalone Code	Describes the professional component only, technical component only or global test only of a selected diagnostic test. Modifier 26 or TC should not be used with a standalone code.
Technical Component (Modifier TC)	Technical component. Portion of a healthcare service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services. Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding Modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize Modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.
General Reimbursement Policy Definitions	

Related Policies and Materials
Documentation Standards for Episodes of Care
Modifier Usage
Multiple Procedure Payment Reduction
Multiple Radiology Payment Reduction
Portable/Mobile/Handheld Radiology Services