| Amerigroup RealSolutions in healthcare | **Reimbursement Policy** |
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**Subject: Modifier 26 and TC: Professional and Technical Component**

| Effective Date: **07/01/17** | Committee Approval Obtained: **10/26/18** | Section: **Coding** |
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*****The most current version of the 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. Under Quick Tools, select Reimbursement Policies > Medicare. *****

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 Medicare Advantage 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 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 participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage 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.

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| **Policy** | Amerigroup Medicare Advantage 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 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, Amerigroup Medicare Advantage 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 Medicare Advantage does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an evaluation and management code.

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| | • There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test.<br><br>Amerigroup Medicare Advantage reserves the right to perform postpayment review of claims submitted with Modifier 26 or Modifier TC. Amerigroup Medicare Advantage 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 Medicare Advantage may recoup or recover monies previously paid on the claim as the provider failed to submit required documentation for postpayment review. |
| **Exemptions** | • The following markets will reimburse the global procedure of newborn hearing screening codes performed in a facility (defined in Exhibit A) that are billed by a physician or other qualified health care professional:<br>  ○ Amerigroup Community Care in New Jersey<br>• Amerigroup Maryland, Inc. only allows reimbursement for use of Modifier 26 or Modifier TC in the following circumstances:<br>  ○ Modifier 26: When reported with radiology and medicine codes<br>  ○ Modifier TC: When reported with radiology codes |
| **History** | • Biennial review approved and effective 10/26/18: Maryland effective 01/01/20<br>• Review approved 11/16/17: Policy template updated<br>• Initial approval 08/01/16 and effective date 07/01/17 |
| **References and Research Materials** | This policy has been developed through consideration of the following:<br>• CMS<br>• State Medicaid<br>• State contracts<br>• American Medical Association: Coding with Modifiers, fifth edition<br>• Optum Learning: Understanding Modifiers, 2015 edition<br>• "Place of Service Codes for Professional Claims." Centers of 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<br>• **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<br>• **Standalone Code**: describes the professional component only, technical component only or global test only of a selected |

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| | diagnostic test; Modifier 26 and TC should not be used with a standalone code<br>• **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<br>• **General Reimbursement Policy Definitions** |
| **Related Policies** | • Modifier Usage<br>• Multiple Procedure Payment Reduction<br>• Multiple Radiology Payment Reduction<br>• Portable/Mobile/Handheld Radiology Services<br>• 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 |
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| **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.