Professional/Technical Components (Modifiers 26, TC)

Reimbursement Policy ID: RPC.0048.2100

Recent review date: 08/2025

Next review date: 11/2026

AmeriHealth Caritas Louisiana reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Louisiana may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

AmeriHealth Caritas Louisiana reimbursement guidelines described in this policy apply to diagnostic laboratory and radiology codes designated by the Centers for Medicare & Medicaid Services (CMS) as comprised of both a professional component (PC) and a technical component (TC) that together constitute the "global" service.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas determines eligibility for separate reimbursement of the professional and technical components of CPT and HCPCS procedure codes using the PC/TC Indicator from the National Physician Fee Schedule Relative Value File (NPFS). The fee schedule uses PC/TC indicators (Professional Component/Technical Component) to designate codes that may be billed with either modifier 26 (Professional Component) or modifier TC (Technical Component). These indicators determine if a code is eligible for separate reimbursement for professional and/or technical services.

NFPF PC/TC Indicators

PC/TC Indicator	Description	PC/TC Reimbursement
0	Represents physician services only.	Not applicable.
1	Diagnostic laboratory or radiology test.	Applicable with appropriate modifier.
2	PC only.	Not applicable
3	TC only.	Not applicable.
4	Global service only.	Not applicable
5	Incident to codes.	Not applicable.
6	Physician interpretation of laboratory test.	Not applicable.
7	Physical therapy service for which no payment is made.	Not applicable.
8	Code for physician interpretation.	Not applicable.
9	PC/TC concept does not apply.	Not applicable.

For example, procedure codes from the NPFS with Indicator 1 are comprised of a technical and professional component which together constitute the global service. The professional and technical components of these procedure codes may be reimbursed separately when reported with the correct modifier (26 or TC) indicating the applicable service component. Providers must append the appropriate modifier (26 or TC) corresponding to either the professional (modifier 26) or technical service (modifier TC) component to these procedures to the procedure code to receive separate reimbursement.

The concept of professional and technical component splits (PC/TC) does not apply to inpatient services since these codes describe professional inpatient services. Inpatient claims require use of “21” as the place of service. It is the only recognized place of service designation when the PC/TC indicator is "8." All other place of service designations are inappropriate.

Procedure codes with PC/TC Indicator ≠ 1 are not reimbursable by [Insert plan name] when reported with modifiers for professional or technical service components.

Definitions

Global service
Global Services include a professional and a technical component. When providers bill a global service, they assert that the same physician or other qualified health care professional provided the supervision, interpretation, and report of the professional services, as well as the technician, equipment, and facility needed to perform the procedure. Global services are identified by reporting the appropriate procedure code with no modifier(s) indicating either the professional or technical components of that procedure.

Professional component
The portion of a billed procedure encompassing only the professional services personally rendered and documented by the billing provider, correctly reported either by appending the appropriate modifier to the global (i.e., complete) procedure code, or with the corresponding stand-alone code describing the professional constituent(s) of the applicable diagnostic test.

Technical component
The portion of a billed procedure encompassing the use of technical staff, equipment, facility, and related infrastructure employed in the performance of that procedure, is correctly reported either by appending the appropriate modifier to the global (i.e., complete) procedure code, or with the corresponding stand-alone code describing the technical constituent(s) of the applicable diagnostic test.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. Centers for Medicare and Medicaid Services (CMS) PFS and Relative File Values, https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files
IV. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c13.pdf
V. The National Correct Coding Initiative (NCCI) in Medicaid.
VI. Louisiana Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

08/2025	Reimbursement Policy Committee Approval
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by [insert plan name] from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section
	Precedes Act 319