# REIMBURSEMENT POLICY STATEMENT
# Marketplace

| Policy Name & Number | Date Effective |
|---|---|
| Modifier 26 and TC: Professional and Technical Component-MP-PY-1475 | 06/01/2026 |
| **Policy Type** | |
| **REIMBURSEMENT** | |

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

| This policy applies to the following Marketplace(s): | | | |
|---|---|---|---|
| ☒ **Georgia** | ☒ **Indiana** | ☒ **Ohio** | ☒ **West Virginia** |

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A. Subject

**Modifier 26 and TC: Professional and Technical Component**

B. Background

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), a modifier is used to report that a service or procedure has been altered by a specific circumstance without changing its definition or code. Modifiers may also convey additional information about a service, such as when the service was performed more than once, unusual events occurred, or a service was performed by more than 1 provider and/or in more than 1 location.

Current Procedural Terminology (CPT®) codes offer providers a uniform language for reporting medical services and procedures to increase accuracy and efficiency, and for administrative purposes such as claims processing and developing guidelines for medical care review. Certain procedures described by a single CPT® code consist of 2 distinct components: the professional component and the technical component. When the professional component is performed separately by a provider, it is identified by appending modifier 26. In this scenario, the facility bills the technical component using the same CPT® code with modifier TC. This allows the professional and technical components of the service to be billed separately by the provider and the facility.

C. Definitions

- **Global Procedure/Service** – Represents both the professional and technical component as a complete procedure or service identified by reporting the procedure without modifier 26 or TC.
- **Modifier 26 (Professional Component)** – Used to indicate when a provider or other qualified health care professional renders the supervision and interpretation portion of a service or procedure and the preparation of a written report.
- **Modifier TC (Technical Component)** – Used to indicate the technical personnel, equipment, supplies, and institutional charges of a service or procedure.

D. Policy

I. CareSource expects providers and facilities to adhere to national coding guidelines and standards when utilizing modifiers.

II. Modifier 26

A. Modifier 26 is appended to the appropriate CPT® code to indicate that only the professional component of a service is being billed.

B. Modifier 26 is also used to report the professional component of a test when the provider performs the service while using equipment owned by a hospital or facility.

III. Modifier TC

A. Modifier TC is appended to the appropriate CPT® code to indicate that only the technical component of a service is being billed.

B. Reimbursement for the technical component is generally made to the facility or practice that provides the supplies, equipment, and/or clinical staff such as technicians.
C. Payment for the technical component includes the practice expense and the malpractice expense associated with the service.
D. Hospitals are typically exempt from appending modifier TC because they are presumed to be billing for the technical component of any onsite service.

IV. Global procedure/service
A. A global service is reported by submitting the eligible CPT® code without modifier 26 or TC. Reimbursement includes the equipment, supplies, and technical support, as well as interpretation and reporting of test results.
B. Modifiers are not necessary to report a global service because payment for both components is included in the reimbursement.

V. Exclusions
A. Do not append modifier 26 when there is a dedicated code to report only the professional component of a service (eg, 93010 electrocardiogram, routine ECG with at least 12 leads; interpretation and report only).
B. Do not append modifier TC when there is a dedicated code to report only the technical component of a service (eg, 93005 electrocardiogram: tracing only, without interpretation and report).
C. CareSource does not allow reimbursement for use of modifier 26 or modifier TC when
1. it is reported with an Evaluation and Management (E&M) code
2. a dedicated code exists that describes the professional component only, technical component only or global test only of a selected diagnostic test

VI. Duplicate billing
A. CareSource considers the following scenarios to be duplicate billing when submitted for the same member on the same date of service. Only the first charge approved by CareSource is eligible for reimbursement. All subsequent charges are considered duplicate services and are not eligible for separate reimbursement.
1. when 1 provider reports a global procedure and a different provider reports the same procedure with modifier 26 or modifier TC
2. when 1 provider reports a procedure with modifier 26 and a different provider reports a global procedure
3. when 1 provider reports a procedure with modifier TC and a different provider reports a global procedure

VII. CareSource may request documentation for post-payment review of claims submitted with modifier 26 or modifier TC. If documentation is not provided, CareSource may recoup previously paid claims.

E. State-Specific Information
NA

F. Conditions of Coverage
Reimbursement policies are designed to assist providers when submitting claims to CareSource and are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement of claims may be subject to limitations and/or qualifications. Reimbursement will be established based on a review of the actual services provided to a member and will be determined when the claim is received for processing. To ensure HIPAA compliance, please use self-service channels for member eligibility verification.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee payment claims.

G. Related Policies/Rules
Electrocardiogram (EKG/ECG) Interpretation and Imaging Interpretation

H. Review/Revision History

| | DATE | ACTION |
|---|---|---|
| **Date Issued** | 11/29/2023 | New policy. Approved at Committee. |
| **Date Revised** | 09/10/2025<br><br><br><br>02/25/2026 | Periodic review. Changed physician to provider where applicable. Updated references. Approved at Committee.<br>Periodic review. Edited for clarity. Updated references. Approved at Committee. |
| **Date Effective** | 06/01/2026 | |
| **Date Archived** | | |

I. References
1. CPT® code set overview. American Medical Association. Updated January 23, 2026. Accessed January 28, 2026. www.ama-assn.org
2. *Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements*. Centers for Medicare and Medicaid Services. Updated December 19, 2025. Accessed January 28, 2026. www.cms.gov
3. What are medical coding modifiers? AAPC. Updated August 19, 2022. Accessed January 28, 2026. www.aapc.com