REIMBURSEMENT POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Modifier 26 and TC: Professional and Technical Component-NV MP-PY-1656	01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we 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.

Table of Contents

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 provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. It may also provide more information about a service, such as the service was performed more than once, unusual events occurred, or it was performed by more than 1 physician and/or in more than 1 location.

Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, increasing accuracy and efficiency, and are also used for administrative management purposes, such as claims processing and developing guidelines for medical care review. Some procedure coding, described by a single CPT code, is comprised of 2 distinct portions: a professional component (26) and a technical component (TC). When the professional component of 1 such procedure is performed separately, the specific service performed by the physician may be identified by adding CPT modifier 26. In this scenario, the facility provides the technical component of a service/procedure, billing the same procedure code with modifier TC. In this way the components of the service can be separately billed by the provider and 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 physician 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. To claim only the professional portion of a service, CPT instructs professionals (or providers) to append modifier 26 to the appropriate CPT code.

B. Modifier 26 is also used to bill for the professional component portion of a test when the provider utilizes equipment owned by a hospital/facility.

III. Modifier TC
   A. The payment for the technical component portion also includes the practice expense and the malpractice expense.
   B. To claim only the technical portion of a service, append modifier TC to the appropriate CPT code.
   C. Fees for the technical component are generally reimbursed to the facility or practice that provides or pays for the supplies, equipment, and/or clinical staff (technicians).
   D. Hospitals are typically exempt from appending modifier TC, because it is assumed that the hospital is billing for the technical component portion of any onsite service.

IV. Global procedure/service
   A. A global service is identified by reporting the eligible code without modifier 26 or TC. In such cases, the provider is reimbursed for the equipment, supplies, and technical support, as well as the interpretation of the results and the report.
   B. When reporting a global service, modifiers are not necessary to receive payment for both components of the service.

V. Exclusions
   A. Do not append modifier 26 if there is a dedicated code to describe only the professional/physician component of a given service (eg, 93010 electrocardiogram, routine ECG with at least 12 leads; interpretation and report only).
   B. Do not append modifier TC if there is a dedicated code to describe the technical component (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. There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test.

VI. Duplicate billing
   A. When 1 provider reports a global procedure and a different provider reports the same procedure with a professional (26) or technical (TC) component modifier for the same patient on the same date of service, the first charge approved by CareSource will be eligible for reimbursement, and subsequent charges processed will be considered duplicate services and will not be eligible for separate reimbursement.
   B. When 1 provider reports a procedure with a professional (26) and a different provider reports a global procedure for the same patient on the same date of service, the first charge approved by CareSource will be eligible for

reimbursement, and subsequent charges processed will be considered duplicate services and will not be eligible for separate reimbursement.

C. When one provider reports a procedure with a technical (TC) component modifier and a different provider reports a global procedure for the same patient on the same date of service, the first charge approved by CareSource will be eligible for reimbursement and subsequent charges processed will be considered duplicate services and will not be eligible for separate reimbursement.

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. 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. Health care providers and office staff are encouraged to use self-service channels to verify member eligibility.

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 claims payment.

F. Related Policies/Rules

Electrocardiogram (EKG/ECG) Interpretation and Imaging Interpretation

G. Review/Revision History

	DATE	ACTION
Date Issued	05/21/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. CPT® overview and code approval. American Medical Association. Accessed May 2, 2025. www.ama-assn.org
2. *Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements*. Centers for Medicare and Medicaid Services. December 13, 2024. Accessed May 2, 2025. www.cms.gov