REIMBURSEMENT POLICY STATEMENT
North Carolina Marketplace

Policy Name & Number	Date Effective
Modifier 26 and TC: Professional and Technical Component- NC MP-PY-1476	03/01/2024
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.

A. Subject

Modifier 26 and TC: Professional and Technical Component

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accur5d912 0 612 792 reW*n0.0003 792 reW*( )]TJ

- **Modifier TC (Technical Component)** ï 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. The professional component is outlined as a physicianôs service, which may include technician supervision, interpretation of results, and a written and signed report.

B.

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, for example, 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 one 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 one provider reports a procedure with a professional (26) and a different provider reports

approved by