Coding Policy

Modifiers -TC and -26: Technical and Professional Components for Services Performed in Facilities

CODING POLICY NUMBER: 95

Effective Date: 1/1/2025

Last Review Date: 1/2025

Next Annual Review: 2026

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

DEFINITION:
PC/TC Indicator 1: Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes.

I. Modifier **TC** is used to report the technical component of a procedure. The CPT description for modifier **TC** says, "*Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier '**TC**' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize*

*modifier **TC**. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles."*

II. Modifier **26** is used to report the professional component of a procedure. The CPT description for modifier **26** says, *"Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier **26** to the usual procedure number."*

III. Hospitals must provide directly or under arrangement all services furnished to patients admitted to the hospital as inpatient or outpatient status. Only in cases where the patient leaves the hospital and obtains the service elsewhere is the hospital not required to bill for the service. If a specimen (e.g., tissue, blood, urine) is taken from a hospital patient, the facility or technical component (TC) of the diagnostic test must be billed by the hospital.

IV. Company will assume a **TC** modifier on facility claims for any code listed on the Medicare Physician Fee Schedule with a PC/TC status indicator of "1."

V. Company will assume a **26** modifier on professional claims for any code listed on the Medicare Physician Fee Schedule with a PC/TC status indicator of "1" for services provided in a facility.

PROCEDURE

GENERAL

Facilities may bill TC-eligible codes with or without modifier **TC**. For any code with a PC/TC indicator of "1" on the Medicare Physician Fee Schedule, Company will pay only the technical component to facilities, even if the code is billed without modifier **TC.**

For any code with a PC/TC indicator of "1" on the Medicare Physician Fee Schedule, Company will pay only the professional component for professional charges performed in a facility, even if the code is billed without modifier **26**.

If the code has only a technical component and no professional component, and the service is performed in a facility, professional charges will be denied as provider responsibility. Payment for this service is the responsibility of the facility, as it is included in the facility payment.

REFERENCES

1. Provider Manual/ProvLink
2. Current Procedural Terminology (CPT)
3. CMS: Medicare Desck Reference for Hospitals

POLICY REVISION HISTORY

Date	Revision Summary
1/2001	**Original policy effective date**
1/2023	Annual review. Converted to new template 5/2023.
1/2024	Annual review. No changes to policy.
1/2025	Annual review. No changes to policy.