Priority Health	BILLING POLICY No. 023

PROFESSIONAL AND TECHNICAL COMPONENTS STATUS INDICATORS

Effective date: Nov. 11, 2024 Date of origin: Sept. 2024	Review dates: 2/2025

APPLIES TO
All products

DEFINITION
This policy defines reimbursement for services that have professional or technical splits based on adoption of the CMS professional component (PC) and technical component (TC) status indicators. These are outlined in the Medicare physician fee schedule (MPFS) and outlines when services can be billed with a PC/TC component and when this concept is not applicable.

0 Physician Service Codes
1 Diagnostic Tests
2 Professional Component Only Codes
3 Technical Component Only Codes
4 Global Test Only Codes
5 Incident to Codes
6 Laboratory Physician Interpretation Codes
7 Physical Therapy Services
8 Physician Interpretation Codes
9 Not Applicable

POLICY SPECIFIC INFORMATION
PC/TC Status Indicator 0

- Status indicator of 0 indicates the service is a physician service. These services can't be split into a technical and/or professional component. Examples of physician services include office visits, office procedures, surgical services and injections.

PC/TC Status Indicator 1

- Status indicator of 1 indicates the service is a diagnostic test. Services assigned this indicator can be reported as a global service or split into a professional component (26 modifier) and technical component (TC modifier). The appropriate modifier must be appended for accurate reporting.
- Physician services reported in a hospital inpatient or outpatient setting are reported as professional element of the diagnostic service only. The facility reports the technical components of these services. This applies to professional claims in place of service 19, 21, 22, 23. Claims will deny if the applicable modifier is not reported in these settings.
- Services are reimbursed at the professional component.

PC/TC Status Indicator 2

- Status indicator of 2 indicates the code is defined within its definition as a professional component only. It isn't appropriate to append modifier 26 or TC to these services.
- These services are payable to providers for place of service 11, 19, 22, 23, 24, 26, 34, 52, 56, 61.

PC/TC Status indicator 3

- Status indicator of 3 indicates the code is defined within its definition as a technical component only. It isn't appropriate to append modifier 26 or TC to these services.
- Due to the technical element of these services, these aren't payable to providers for place of service 19, 22, 23, 24, 26, 34, 52, 56, 61. These would be reported by the facility.

PC/TC Status Indicator 4

- Status indicator of 4 identifies global services only. These services are classified as including both a professional and technical component based on the code descriptions. These codes are only payable as global tests. Modifiers 26 and TC aren't appropriate for these services.
- These aren't payable to providers for place of service 19, 22, 23, 24, 26, 34, 52, 56, 61.

PC/TC Status Indicator 5

- Status indicator of 5 identifies services as "Incident to codes". These services aren't applicable for modifier 26 or TC as they include services performed by auxillary staff who are employed by and work under the direct supervision of the physician.
- As defined by CMS and AMA CPT, these services aren't payable to providers for place of service 19, 22, 23, 24, 26, 34, 52, 56, 61.

PC/TC Status Indicator 6

- Status indicator 6 identifies clinical lab services that allow for separate reimbursement to physicians who interpret the test results. Modifier 26 is appropriate for these services. TC modifier isn't appropriate.
- Lab interpretations are reimbursed under the clinical lab fee schedule.
- Services are payable in a facility setting.

PC/TC Status Indicator 7

- Status indicator 7 identifies services performed by therapists in a private practice. These services aren't payable in the hospital inpatient or outpatient setting when performed by a physical therapist, occupational therapist and/or speech/language pathologists who are in private practice (not employed by facility).

PC/TC Status Indicator 8

- Status indicator 8 identifies services payable in the inpatient setting for interpretation of abnormal smear results. Only CPT 85060 has this designation.
- These services aren't payable to an outpatient facility or any professional settings. Only place of service 21 is payable.

PC/TC Status Indicator 9

- Status indicator 8 indicates the concept of professional or technical components don't apply.

CMS updates status indicators on a quarterly basis, so it's essential to remain up to date on changes to codes associated with these indicators. We'll update our requirements in alignment with CMS.

Modifiers

- **26**: Professional Component
- **TC**: Technical Component

Definitions

- **Global Services**: A global service includes both a technical element and professional element within the description of the service.

- **Technical Component**: A technical component represents the equipment, facility costs and staffing required to perform a service. These services may be represented with the TC modifier or may be defined by code definition as technical services.

- **Professional Component**: The professional component represents the physician or health care providers portion of the service(s). This may include supervision, interpretation and documentation of report. The interpretive report is the written narrative that details the services, treatment, and associated diagnosis. These services are identified by the use of modifier 26 or when the definition of the code specifically details professional services only.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added "Disclaimer" section