



Manual: Reimbursement Policy

Policy Title: **Technical Component (TC), Professional Component (PC/26), and Global Service Billing**

Section: Modifiers

Subsection: None

Date of Origin: 1/1/2000                      Policy Number: RPM008

Last Updated: 1/8/2021                      Last Reviewed: 1/13/2021

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### Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

This policy applies to all provider types. While the PC/TC indicator is located on the Physician Fee Schedule, the components of the code and code definition remain the same when billed by facilities and other provider types.

### Reimbursement Guidelines

#### A. Designating Procedure Codes With Technical and/or Professional Components

Many, but not all, procedure codes are comprised of a technical and/or professional component. The CMS Physician Fee Schedule (MPFSDB) PC/TC indicator defines whether a procedure code includes a technical component, a professional component, both the TC and PC components, or neither (when the concept does not apply). The place of service where the procedure is performed and who owns the equipment used is what determines which provider(s) and provider type(s) may bill the various components of the service.

1. Procedures that are comprised of both a technical and professional component are identified on the National Medicare Physician Fee Schedule Database (MPFSDB) in Field 20 with a Professional Component (PC)/Technical Component (TC) Indicator of "1".
2. It is never appropriate for the technical and professional components to be unbundled and reported separately under the same TIN number (whether on separate line items of a single claim or on separate claims). (CPT Assistant<sup>3</sup>)
  - a. When determining if the technical and professional components were performed by the "same provider" or by different providers, if both components will be billed under the same tax ID number (TIN) then both components were performed by the same provider and are not eligible to be reported as separate components. Instead the global service should be billed without modifier TC or 26.

Example:

If the x-ray equipment is jointly owned by the physicians in a clinic, then the clinic must obtain a separate TIN number in order to separately submit the technical component (TC) of the service.

If the clinic has not obtained a separate TIN (and a separate contract with Moda Health to be participating), then the global service must be billed by the interpreting clinic physician. The clinic needs to manage the equitable distribution of reimbursement for the technical component of the service internally through accounting and the joint ownership agreement for the shared equipment.

- b. Only the components that have been actually performed by the billing provider may be billed to Moda Health. If only one of the components has been performed, charges may not be submitted to Moda Health for the component that has not been performed. The instructions in CMS Transmittal 1892/CR6733 are both optional and conditional, and do not apply to claims submitted to Moda Health.

- c. Note: While CMS does sometimes instruct providers to re-bill the service as separate professional and technical component procedure codes, our research indicates this is specifically related to the calculation of CMS bonus payments in a health professional shortage area (HPSA), and does not apply to billing to commercial carriers such as Moda Health.

- d. Purchased Services Billing (aka Anti-markup Payment Limitation).

Moda Health does not allow technical and professional components to be unbundled and reported as separate line items (same claim or split claim) under the same TIN number, even for purchased services arrangement billing.

- i. Our claims processing and clinical editing systems are not able to bypass technical and professional component unbundling edits based on the CMS1500 field 20 (Outside Lab?) being marked as “Yes” as instructed by CMS. (CMS<sup>16, 17</sup>, Noridian<sup>18</sup>) Technical and Professional component unbundling edits use the Tax Identification Number (TIN) submitted on the claim to determine same provider TC/26 unbundling edits.
- ii. For purchased services with outside reference laboratories, the global procedure code may be submitted with modifier 90 Reference Laboratory. When billing this way, venipuncture services are not eligible for separate reimbursement. (Moda<sup>B</sup>)
- iii. For radiology services where the studies are performed at your facility/clinic using your equipment and then sent out to another provider for purchased services interpretation and reporting, a modifier is not available to use as the radiology-equivalent of modifier 90. Alternatives for resolving the unbundling limitation and Moda’s restriction to not submit technical and professional components separately under the same TIN include:
  - a) Use of a separate business TIN for submitting claims for purchased diagnostic services.
  - b) The other provider may contact Moda Health’s Provider Network team and contract with Moda directly.

- iv. This does not mean that Moda Health approves of marking up the pricing on any purchased services for outside diagnostic tests. The anti-markup payment limitations do apply.

## **B. The Professional Component Only**

1. Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 1, or 8 (see field 20 on the MPFSDB) will be allowed with modifier 26 appended.
2. Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 6 (see field 20 on the MPFSDB) require that modifier 26 be appended. A clinical edit will deny and require a corrected claim if modifier 26 is missing.
3. Procedure codes with a PC/TC indicator of 1 may not be reported as a global service when performed in an Inpatient or Outpatient hospital or skilled nursing setting; only the professional component may be billed.
4. Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, or 9 will be denied when submitted with modifier 26 appended.
  - a. Physician Services Only – PC/TC Indicator “0”
    - i. PC/TC indicator of “0” identifies codes that describe physician services. Examples include visits, consultations, surgical procedures. This indicator “0”, also includes certain laboratory/pathology consultations or interpretation/reports that do not involve any technical component.
    - ii. Physician services codes (indicator “0”) cannot be split into professional and technical components.
    - iii. The lab procedure codes with PC/TC indicator “0” are not eligible to be reimbursed to facilities.
      - 1) Exception: If the facility is on an APC contract and these codes are the only service billed for the date of service.
      - 2) If a non-APC facility claim is submitted with a lab procedure code with PC/TC indicator “0,” the line item will be denied with explanation code u08. See section B.5.b.
  - b. Molecular Pathology procedure codes – PC/TC indicator “9”
    - i. The CPT book Molecular Pathology sub-section guidelines state “The results of the procedure may require interpretation by a physician or other qualified health care professional. When only the interpretation and report are performed, modifier 26 may be appended to the specific molecular pathology code.” (AMA19)
    - ii. However, the CMS Physician Fee Schedule lists PCTC indicator 9 for CPT 81105 – 81479.
    - iii. Moda Health follows the CMS guidelines of the Physician Fee Schedule PCTC indicator and will deny Molecular Pathology procedure codes submitted with modifier 26.

5. Denial explanation codes

a. Modifier inconsistent with procedure

i. Denial explanation codes:

- 514 The modifier that was billed is invalid for the procedure.
- n59 The professional component modifier 26 is not appropriate with a 100% technical procedure.
- t35 Per the MPFS, procedure code describes only the technical portion of a service or diagnostic test. A modifier is not appropriate.
- t38 Per the MPFS, procedure code describes the physician work portion of a diagnostic test. The modifier is not appropriate.
- t40 Per Medicare, a modifier on the line item is not appropriate for the billed procedure code.
- u13 The modifier used is inconsistent with the procedure code.
- z52 A modifier on the line is not appropriate for the procedure code.
- z63 The professional component modifier 26 is not appropriate with a 100% technical procedure.

ii. 835 CARC/RARC denial combination:

- CARC 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.  
Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)
- RARC n/a n/a

b. Physician Services Only denials, see.

Denial explanation code:

- u08 (*This provider type/provider specialty may not bill this service..*)

835 CARC/RARC denial combination:

- CARC 170 (Payment is denied when performed/billed by this type of provider.  
Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)
- RARC N95 (This provider type/provider specialty may not bill this service.)

**C. The Technical Component Only**

1. Procedure codes with a Professional Component (PC)/Technical Component (TC) Indicator of 1 (see field 20 on the MPFSDB) will be allowed when modifier TC is appended.
2. Procedure code with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 6, 7, 8, or 9 will be denied when submitted with modifier TC appended.

3. The denial explanation code will indicate that the procedure code is inconsistent with the modifier used:

Denial explanation codes:

- 514 The modifier that was billed is invalid for the procedure.
- n59 The professional component modifier 26 is not appropriate with a 100% technical procedure.
- t35 Per the MPFS, procedure code describes only the technical portion of a service or diagnostic test. A modifier is not appropriate.
- t38 Per the MPFS, procedure code describes the physician work portion of a diagnostic test. The modifier is not appropriate.
- t40 Per Medicare, a modifier on the line item is not appropriate for the billed procedure code.
- u13 The modifier used is inconsistent with the procedure code.
- z52 A modifier on the line is not appropriate for the procedure code.
- z63 The professional component modifier 26 is not appropriate with a 100% technical procedure.

835 CARC/RARC denial combination:

- CARC 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.  
Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)
- RARC n/a n/a

#### **D. Medical Direction Of Clinical Laboratory Services Automated Tests**

1. Moda Health follows CMS policy for all lines of business for medical direction and supervision of automated clinical laboratory tests.
  - a. Only procedure codes with a PC/TC indicator of 1, 6, or 8 may be reported with modifier 26 appended.
  - b. Automated lab tests do not have a PC/TC indicator of 1, 6, or 8.
    - i. These procedure codes for automated tests are assigned indicator "9" "Concept of a professional/technical component does not apply." By this CMS is indicating these procedure codes do not have a professional component which can be reported by a physician/pathologist.
    - ii. Automated lab test procedure codes are not eligible for reimbursement when submitted with modifier 26 appended. The line item will deny to provider liability.
  - c. Payment to the hospital or Independent Clinical Laboratory includes payment for the pathologist's medical direction and supervision services to ensure that the automated laboratory machines produce accurate and reliable test results. The pathologist serving as the medical director for the laboratory needs to seek payment from the hospital or independent laboratory for their medical director services.

2. CMS policy is considered to be the community standard for Commercial laboratory services as well as for Medicare and Medicaid lines of business. (<sup>13</sup>, AMA<sup>3, 15</sup>)

#### **E. Reviewing Diagnostic Data During Evaluation and Management Services**

1. Per the CPT Book Evaluation and Management (E/M) Services Guidelines, reviewing and analyzing diagnostic tests and other information is part of the Medical Decision Making component of E/M services. (AMA<sup>10</sup>) Emergency room physicians, orthopedic surgeons, trauma specialists, surgeons, internists, family physicians, podiatrists and other treating physicians who routinely review pathology results, chest x-rays, EKGs, and/or other diagnostic data evaluation as an integral part of their reimbursed patient care services are not entitled to an additional reimbursement of a professional component for that review. The review and evaluation of diagnostic data is covered by the reimbursement for office visit and treatment. (AMA<sup>11</sup>)
2. A separate, signed interpretation and report similar to that which would be prepared by a specialist in the field is required to support the billing of the professional component of such diagnostic tests. (CMS<sup>12</sup>)

#### **F. Technical Services Provided to Hospital Patients**

1. Moda Health applies the CMS guidelines and requirements to all claims from all lines of business which require facilities to bill for the technical component of pathology services and other diagnostic services, even when provided under arrangement or subcontracted to another provider. Moda Health will reimburse the facility for these technical services. Global payment arrangements (e.g. APC, DRG) include reimbursement for these technical services, whether provided by the facility directly, or by a subcontracted provider.
2. Moda Health will deny the global code or technical component of services billed by a professional provider or outside laboratory for services performed in a facility (e.g. place of service 21, 22, 23, etc.). The professional provider may report only the professional component (-26) to Moda Health.
3. The subcontracted provider with whom the hospital has an arrangement to provide any technical service must look to the facility for reimbursement for these subcontracted services.

#### **G. PC/TC Indicator "8" Physician Interpretation Codes**

PC/TC indicator "8" is defined as "...separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient..." CMS has designated place of service "21" as inpatient and it is the only recognized place of service designation when the PC/TC indicator is '8.' All other place of service designations are inappropriate.

## Codes, Terms, and Definitions

### Acronyms Defined

Acronym		Definition
AMA	=	American Medical Association
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
EOCCO	=	Eastern Oregon Coordinated Care Organization
HCPCS	=	Healthcare Common Procedure Coding System
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
PC	=	Professional Component
RVU	=	Relative Value Unit
TC	=	Technical Component
TIN	=	Tax Identification Number

### Global Terms & Modifiers:

Modifier/Term	Definition
No modifier used	Unmodified CPT codes are intended to describe both the technical and professional components of a service. The professional and technical components together are referred to as the "global service." (CPT Assistant <sup>3</sup> )
Modifier 26	<b>Professional Component:</b> Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.
Modifier TC	<b>Technical Component.</b> 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.
Global service	Unmodified CPT codes are intended to describe both the technical and professional components of a service. The professional and technical components together are referred to as the "global service." (CPT Assistant <sup>3</sup> )

Modifier/Term	Definition
Modifier 90	<b>Reference (Outside) Laboratory.</b> When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

Status Indicators:

The Medicare Physician Fee Schedule (MPFSDB) Professional Component (PC)/Technical Component (TC) (PC/TC) Indicators in use are:

Indicator	Indicator Definition
0	= Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.
1	= Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.  The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.  The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.
2	= Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.  An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.



Indicator	Indicator Definition
3	<p>= Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.</p> <p>An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes.</p> <p>The total RVUs for technical component only codes include values for practice expense and malpractice expense only.</p>
4	<p>= Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.</p>
5	<p>= Incident to codes: This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.</p> <p>Payment may not be made by A/B MACs (B) for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.</p>
6	<p>= Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.</p>
7	<p>= Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.</p>
8	<p>= Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.</p> <p>No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.</p>
9	<p>= Concept of a professional/technical component does not apply.</p>

## **Coding Guidelines**

“If the technical and professional components of the service are performed by the same provider, then it is not appropriate to report the components of the service separately.” (CPT Assistant<sup>3</sup>)

“When the service is furnished to a hospital outpatient or inpatient, the facility bills the technical component, which includes the cost of equipment, supplies, technician salaries, etc. If the interpreting physician is not paid by the facility for services but will instead be billing the carrier separately, the physician may bill only for the professional component.” (CPT Assistant<sup>3</sup>)

“Professional Component (PC)/Technical Component (TC) Indicator  
9 = Concept of a professional/technical component does not apply.” (CMS<sup>14</sup>)

“In closing, when reporting the technical component of a procedure or service, it is important to familiarize yourself with the various reporting requirements of individual insurance companies in your area. These reporting and reimbursement policies may vary from one insurance company to another.” (CPT Assistant<sup>3</sup>)

The hospital must bill for the technical component portion of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist, or other provider. (CPT Assistant<sup>3</sup>, CMS<sup>7</sup>, Medicare Desk Reference for Hospitals<sup>8</sup>, CMS<sup>9</sup>)

“For services furnished to hospital outpatients or inpatients, the physician may bill only for the professional component...This requirement applies even if the service for a hospital patient is performed in a physician's office.” (CPT Assistant<sup>3</sup>)

“Effective on or after January 1, 2011, only the hospital may bill for the TC of a physician pathology service provided to an inpatient or outpatient.” (Medicare Claims Processing Manual, Laboratory Services chapter<sup>7</sup>)

“Hospitals must provide directly or under arrangements all services furnished to hospital outpatients. Therefore, 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. Only in cases where the patient leaves the hospital and obtains the service elsewhere is the hospital not required to bill for the service...At the request of the industry, the implementation of this rule was delayed to allow independent laboratories and hospitals sufficient time to negotiate arrangements...through February 29, 2012.” (Medicare Desk Reference for Hospitals<sup>8</sup>)

## **Cross References**

- A. “Moda Health Reimbursement Policy Overview.” Moda Health Reimbursement Policy Manual, RPM001.
- B. “Routine Venipuncture and/or Collection of Specimens.” Moda Health Reimbursement Policy Manual, RPM012.

## References & Resources

1. American Medical Association. *Current Procedural Terminology (CPT) 2010*. Appendix A – Modifiers. Chicago, Illinois: AMA Press, 2010.
2. *2010 HCPCS Level II, Expert*. Appendix 2 – Modifiers. USA: Ingenix, 2009.
3. American Medical Association. “Technical vs. Professional Component.” *CPT Assistant*. May 1999: 1-2.
4. “Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation.” CMS Transmittal 1892/CR6733. January 15, 2010.
5. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 1, § 30.2.9.
6. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. American Medical Association, 2004.
7. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 16 – Laboratory Services, §80.2.1.
8. Whitehead, Trudy, CPC-H, CMAS and Magnani, Regina, RHIT, eds., *Medicare Desk Reference for Hospitals*. October 2012.
9. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 16 – Laboratory Services, §40.3.
10. American Medical Association. “Evaluation and Management (E/M) Services Guidelines.” *CPT Book, Professional Edition*. Chicago: AMA Press, 2013, p. 10.
11. Medi-Cal. *Pathology: Billing and Modifiers*. Medi-cal.ca.gov. Found under: Publications, Provider Manuals, General Medicine, Pathology: Billing and Modifiers. Last accessed 4/2/2013. [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp) .
12. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 13 – Radiology Services and Other Diagnostic Procedures, §100.1.
13. Comment: This is one instance where CMS guidelines do not agree with information from the *College of American Pathologists Professional Relations Manual* as cited by the AMA in “Technical vs. Professional Component,” *CPT Assistant*, May 1999 (CMS<sup>3</sup>). Note, this article also concludes the discussion of this issue by stating, “*In closing...it is important to familiarize yourself with the various reporting requirements of individual insurance companies in your area. These reporting and reimbursement policies may vary from one insurance company to another.*”  
  
Moda Health follows CMS guidelines; see RPM001 which states “*In rare cases discrepancies exist between guidelines on a specific topic from two or more sources listed above. In these situations, Moda Health has sole discretion to determine which guideline to use in the development of Moda Health Reimbursement Policy.*”

14. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts.
15. American Medical Association. “Coding Communication: Professional Component for Clinical Laboratory Services (CPT codes 80048-89356).” *CPT Assistant*. August 2005: 9.
16. CMS. “Claims Processing Instructions for Diagnostic Tests Subject to the Anti-Markup Pricing Limitation.” *MLN Matters*, MM6371, February 13, 2009. < <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6371.pdf>>.
17. CMS. *Medicare Claims Processing Manual* (Pub. 100-04). Chapter 1 General Billing Requirements, § 10.1.1.2 and 30.2.9.
18. Noridian Medicare. “Diagnostic Tests: Purchased or Personally Performed.” Last Updated August 14, 2018; last accessed Jun 3 1, 2020. <https://med.noridianmedicare.com/web/jfb/specialties/radiology/diagnostic-tests-purchased-or-personally-performed> .
19. AMA. “Molecular Pathology.” *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

## **Background Information**

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

#### **IMPORTANT STATEMENT**

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.