Modifier 26

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Modifier 26, defined as "Professional Component," should be added to a procedure code when the provider delivers only the professional aspect of the service.

Global Service

A global service/procedure is when both technical and professional components are performed by one provider.
Modifier 26 indicates only the professional component of a service/procedure, typically billed by a physician. Services with a value of "1" or "6" in the PC/TC Indicator field of the National Physician Fee Schedule can be billed with modifier 26, including radiology, pathology, laboratory, and medicine services.

- *Value "1"* services are diagnostic tests with both components. In hospitals, the TC component is presumed to be billed by the facility; thus, modifier 26 is for the professional component.
- *Value "6"* services are clinical lab tests where separate payment for physician interpretation is allowed. Modifier 26 should be used for these interpretations. Do not use modifier TC for these codes.
- For global services, do not use modifiers TC and 26. No modifier is needed.
- Always bill modifier 26 in the first modifier position.

Supplemental Information

Definitions

Term	Definition
CPT Modifier 26	Professional Component- The exercise of medical judgment, including interpretation of results and a narrative report.
HCPCS Level II Modifier TC	Technical Component- The cost of the equipment supplies and personnel to perform the procedure.

References

Medicare Claims Processing Manual: Chapter 23 - Fee Schedule Administration and Coding Requirements
Section 50.6 – Physician Fee Schedule Payment Policy Indicator File Record Lay0ut
Professional Component (PC)/Technical Component (TC) Indicator; pages 57-60

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104C23.pdf

Informative link to AAPC:

https://www.aapc.com/blog/52001-when-to-apply-modifiers-26-and-tc/

Documentation History

Type	Date	Action
Effective Date	11/20/2020	New Policy
Revised Date	10/19/2022	Reviewed Links
Revised Date	08/16/2023	Verified links
Revised Date	12/12/2024	Verified Links and updated the Templated

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed*