

Coding Policy

Modifiers -TC and -26: Technical and Professional Components for Services

CODING POLICY NUMBER: 95

Effective Date: 10/2026

Last Review Date: 9/2026

Next Annual Review: 2027

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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 |

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Company utilizes PC/TC indicators listed on the Medicare Physician Fee Schedule Database (MPFSDB) to identify those procedure codes which have an appropriate

Professional/Technical split. These codes are to be billed with modifier -26 (Professional Component), modifier -TC (Technical Component), or no modifier if a global test service was rendered or when reporting stand-alone codes.

- II. Modifier **-TC**: Used to report the technical component of a procedure. The CPT description for modifier **-TC** states, *“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.”*
- III. Modifier **-26**: Used to report the professional component of a procedure. The CPT description for modifier **-26** states, *“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.”*
- IV. Global service: A global service encompasses both the professional and technical components of a procedure. Both the technical and professional components of a procedure are performed by the same provider. Modifiers -26 and -TC are not appended to the global test code.
- V. Stand-Alone Procedure Code: These codes denote procedures that by code description are either solely the professional component, solely the technical component, or solely the global service. Modifier -26 and -TC cannot be reported with this code.
- VI. 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.” 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
- VII. Procedure codes with a PC/TC indicator of 1 must not be billed as a global service when performed in a facility setting. Company will reimburse the technical component portion only to facilities. Services should be reported with modifier -TC appended. Company will reimburse the professional component only for professional services performed in a facility, services should be reported with modifier -26 appended.

GENERAL

The Professional/Technical status indicators appear in the Professional Component/Technical Component (PC/TC) indicator column of the Medicare Physician Fee Schedule Database (MPFSDB). CPT or HCPCS codes not marked in the fee schedule as having a professional/technical split are ineligible for reimbursement when billed with either the professional (-26) or technical (-TC) modifiers.

Company recognizes modifier -26 to indicate the professional component only of a diagnostic service or procedure. The professional component includes supervision, interpretation, and a written report of the results/outcome of the applicable procedure rendered to a patient. These professional services are identified by appending modifier -26 to the procedure code.

Company recognizes modifier -TC to indicate the technical component only of a diagnostic service or procedure. The technical component accounts for all equipment, supplies, and clinical staff such as technicians. These technical services are identified by appending modifier -TC to the procedure code and billed by the entity that provided the testing.

Modifier -26 and -TC are not appropriate when appended to an E&M code and will be denied reimbursement.

Modifiers -26 and -TC applied to a stand-alone code is not appropriate and will be denied reimbursement.

When the global procedure is reported without modifier -26 or -TC, reimbursement is permitted when the same physician or qualified healthcare professional performs both the professional and technical components of the service. Additionally, if one provider reports a global procedure and another reports the same procedure with a professional (-26) or technical (-TC) component modifier for the same patient on the same date of service, only the charge received first will be eligible for reimbursement, while subsequent charges will be considered duplicate services and will not be reimbursed separately.

PC/TC STATUS INDICATOR DEFINITIONS:

- **0 = Physician service codes.** This indicator describes physician service codes. Examples include visits, consultations, and surgical procedures. The concept of PC or TC doesn't apply since Medicare doesn't split physician services into professional and technical components.
 - Modifiers -26 and -TC cannot be reported with these codes.
 - The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense.
- **1 = Diagnostic tests or radiology services.** This indicator describes diagnostic tests codes (for example, pulmonary function tests or therapeutic radiology procedures like radiation therapy). These codes generally have both a professional and technical component.
 - Modifiers -26 and -TC can be reported 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 part of chosen diagnostic tests for which there's 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 reported with these codes.
 - The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.
- **3 = Technical component only codes.** This indicator describes stand-alone codes that describe the technical component, like staff and equipment costs, of chosen diagnostic tests for which there's an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also describes codes that Medicare covers only as diagnostic tests and don't have a related professional code.
 - Modifiers -26 and -TC cannot be reported with these codes.
 - The total RVUs for technical component only codes include values for practice expense and malpractice expense only.
- **4 = Global test only codes.** This indicator describes stand-alone codes that have associated codes naming: The professional component of the test only or the technical component of the test only.
 - Modifiers -26 and -TC cannot be reported 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 equal the sum of the total RVUs for the professional and technical components only codes together.
- **5 = Incident to codes.** This indicator describes codes for services covered incident to a physician's service when auxiliary personnel the physician employs and who work under their direct supervision provides them.
 - Modifiers -26 and -TC cannot be reported with these codes.
- **6 = Laboratory physician interpretation codes.** This indicator describes clinical laboratory codes for interpretations by laboratory physicians.
 - Modifier -TC cannot be reported with these codes.
 - The total RVUs for laboratory physician interpretation codes include values for physician, work, practice expense, and malpractice expense.

- **7 = Private practice therapist's service.** Company may not make payment if an independently practicing physical therapist or occupational therapist provided the service to a hospital outpatient or inpatient.
- **8 = Physician interpretation codes.** This indicator describes the professional component of clinical laboratory code 85060 for which separate payment may only be made if the physician interprets an abnormal smear for a hospital inpatient. No payment for code 85060 is allowed for hospital outpatient or non-hospital patients.
 - Modifier -TC may not be reported because payment for the underlying clinical laboratory test is made to the hospital.
- **9 = Concept of a professional or technical component doesn't apply.**

REFERENCES

1. Centers for Medicare & Medicaid Services (cms.gov)
2. Provider Manual/ProvLink
3. American Medical Association. Current Procedural Terminology (CPT)

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.
8/2025	Interim Update. Updated to encompass general guidance on use of modifier TC/26. Changed title from "Modifiers -TC and -26: Technical and Professional Components for Services Performed in Facilities" to "Modifiers -TC and -26: Technical and Professional Components for Services"
9/2025	Annual review. Added section VIII to policy statement, this guidance was on previous policy version, guidance updated for clarity of policy administration.
10/2026	Annual review. No changes to policy.