**PAYMENT POLICY ID NUMBER:** 10-014

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# Professional/Technical Component

**THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.**

## DESCRIPTION:

Global Service – A global service includes both a Technical Component and a Professional Component. When a physician or other health care professional reports a Global Service, the physician is reporting the performance of both the Technical and Professional Component of that code. In appropriate circumstances, the Global Service is identified by reporting the procedure code with no modifier appended.

Technical Component (TC) –The Technical Component represents the technician, equipment and facility needed to perform the procedure. When the technical component is reported separately, the service may be identified by adding the modifier TC to the usual procedure number or by reporting a stand-alone code for technical component only services.

Professional Component (PC) –The Professional Component represents the physician or other health care professional work portion of the procedure and includes the supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative or report to be included in the patient's record, and directly contributes to the diagnosis and/or treatment of the patient. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number or by reporting a stand-alone code for professional component only services.

This policy describes reimbursement for Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) codes based on the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) Professional Component (PC) /Technical Component (TC) Indicators.

**REIMBURSEMENT INFORMATION:**

CMS identifies procedures that have both a professional and technical component. The MPFS 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 MPFS Professional Component (PC)/Technical Component (TC) (PC/TC) Indicators:

| PC/TC Indicator | Description |
|---|---|
| 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 Service |
| 8 | Physician Interpretation Codes |
| 9 | Not Applicable |

**PC/TC Indicator 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 and TC cannot be used with these codes.

**PC/TC Indicator 1 – Diagnostic Tests**

CPT® or HCPCS codes assigned a CMS PC/TC Indicator 1 are comprised of a Professional Component and a Technical Component which together constitute the Global Service. The Professional Component (PC), (supervision and interpretation) is reported with modifier 26, and the Technical Component (TC) is reported with modifier TC.

When a diagnostic procedure with a PC/TC indicator equal to 1 is provided in a facility place of service, Florida Blue will only reimburse the physician for his/her professional services. The technical component of such services is included in the payment to the facility. Professional claims submitted with place of service 19, 21, 22, or 23 for a diagnostic procedure with a PC/TC indicator equal to 1 should be submitted with a modifier 26. If the diagnostic procedure is submitted without the modifier, the procedure will be reimbursed for the professional component only.

Florida Blue allows an exception for newborn hearing screening codes. In the event the physician or other health care professional owns the equipment, global reimbursement is allowed with the hearing screen for a newborn that is performed in a facility location.

When a patient receives services as a hospital inpatient or outpatient, the facility should report the technical component of services that have both a professional and technical component. Physicians and other health care professionals will be reimbursed only for the professional component using modifier 26 or a standalone professional component code as the facility is reimbursed for the technical component of the service.

**PC/TC Indicator 2 – Professional Component Only Codes**

PC/TC indicator 2 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. Modifiers 26 and TC cannot be used with these codes.

Consistent with CMS, Florida Blue will allow reimbursement to physicians and other healthcare professionals for codes identified with a CMS PC/TC indicator 2 when reported in a facility place of service (19, 21, 22, 23, 24, 26, 34, 51, 52, 56, and 61).

**PC/TC Indicator 3 – Technical Component Only Codes**

CPT® or HCPCS codes assigned a CMS PC/TC Indicator 3 are identified as standalone 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. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Neither CPT® modifier 26 nor HCPCS modifier TC can be submitted with these codes.

These codes have no physician work associated with them and are therefore a technical component only code (PC/TC indicator 3). When billed in a facility place of service (19, 21, 22, 23, 24, 26, 34, 51, 52, 56, and 61) they are not payable to the physician but may be paid to the facility. When billed in the office they are payable to the physician.

**PC/TC Indicator 4 – Global Test Only Codes**

Global Test Only Codes PC/TC indicator 4 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. Florida Blue will not reimburse the physician or other qualified health care professional when rendered in a facility POS. When billed in the office they are payable to the physician.

**PC/TC Indicator 5 – Incident to Codes**

PC/TC indicator 5 is defined as “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. Payment may not be made by carriers 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.

Consistent with CMS guidelines, Florida Blue will not allow reimbursement to physicians and other healthcare professionals for codes identified with a CMS PC/TC indicator 5 when reported in a facility place of service (19, 21, 22, 23, 24, 26, 34, 51, 52, 56, and 61). In addition, CPT® coding guidelines for many of the PC/TC indicator 5 codes specify that these codes are not intended to be reported by a physician in a facility setting.

**PC/TC Indicator 6 – Laboratory Physician Interpretation Codes**

PC/TC indicator 6 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.

Consistent with CMS guidelines, Florida Blue will allow reimbursement to physicians and other healthcare professionals for clinical laboratory interpretive services provided in a facility POS identified with a CMS PC/TC indicator 6. Procedure codes with a PC/TC indicator 6 may be reported with modifier 26.

**PC/TC Indicator 7 – Physical Therapy Service**

PC/TC indicator 7, as applied to certain CPT®/HCPCS codes, is described as specific to the services of privately practicing therapists. 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.

**PC/TC Indicator 8 – Physician Interpretation Codes**

PC/TC indicator 8 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 (Blood smear, peripheral, interpretation by physician with written report). No payment is recognized for code 85060 furnished to hospital outpatients or nonhospital patients.

In alignment with CMS, Florida Blue will not reimburse PC/TC Indicator 8 (CPT® code 85060) when reported by a physician or other qualified health care professional with a POS code other than inpatient hospital (POS 21).

**PC/TC Indicator 9 – Not Applicable**

Concept of a professional/technical component does not apply.

**BILLING/CODING INFORMATION:**

The following codes may be used to describe:

**HCPCS Coding/Modifiers:**

| | |
|---|---|
| 26 | Professional Component |
| TC | Technical Component |

**REFERENCES:**


1. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
2. CMS, Medicare Physician Fee Schedule Relative Value File: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
3. Centers for Medicare and Medicaid Services: Medicare Claims Processing Manual, Chapter 16 – Laboratory Services, Sec. 80.2.1
4. Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf


**GUIDELINE UPDATE INFORMATION:**

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|---|---|
| 11/30/2010 | New payment policy |
| 06/19/2012 | Revision- Changed name from BCBSF to Florida Blue |

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|---|---|
| 10/27/2016 | Annual Review |
| 10/12/2017 | Annual Review |
| 09/20/2018 | Annual Review – minor verbiage changes under Reimbursement Information |
| 08/15/2019 | PC/TC Indicator 3 added under Reimbursement Information |
| 09/12/2019 | Annual Review – PC/TC Indicators 0, 2, and 4-9 added under Reimbursement Information |
| 09/10/2020 | Annual Review-minimal verbiage change under “Reimbursement Information:” PC/TC Indicator 3 |
| 09/16/2021 | Annual Review – References updated. |
| 09/15/2022 | Annual Review – no changes |
| 09/14/2023 | Annual Review – References reviewed and updated. |