Keystone First
Family of Health Plans

# Professional/Technical Components (Modifiers 26, TC)

Reimbursement Policy ID: RPC.0048.0100

Recent review date: 10/2025

Next review date: 11/2027

*Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.*

*In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.*

*This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.*

*To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.*

## Policy Overview

Keystone First reimbursement guidelines described in this policy apply to diagnostic laboratory and radiology codes designated by the Pennsylvania Department of Human Services Medical Assistance (PAMA) as consisting of a professional component (modifier 26) and a technical component (modifier TC) that together constitute the "global" service.

## Exceptions

N/A

## Reimbursement Guidelines

Keystone First utilizes the PAMA fee schedule to determine eligibility for separate reimbursement of the professional and technical components of CPT and HCPCS procedure codes based on the provider type, provider specialty, and place of service (POS). Providers must append an appropriate modifier corresponding to either the professional (modifier 26) or technical (modifier TC) service component to receive separate reimbursement.

## Definitions

**Global service**
Global services include a professional and a technical component. When providers bill a global service, they assert that the same individual physician or other qualified health care professional provided the supervision, interpretation, and report of the professional services as well as the technician, equipment, and facility needed to perform the procedure. Global services are identified by reporting the appropriate procedure code with no modifier(s) indicating either the professional or technical components of that procedure.

**Professional component**
The portion of a billed procedure encompassing only the professional services personally rendered and documented by the billing provider, correctly reported either by appending the appropriate modifier to the global (i.e., complete) procedure code, or with the corresponding stand-alone code describing the professional constituent(s) of the applicable diagnostic test.

**Technical component**
The portion of a billed procedure encompassing the use of technical staff, equipment, facility, and related infrastructure employed in the performance of that procedure, is correctly reported either by appending the appropriate modifier to the global (i.e., complete) procedure code, or with the corresponding stand-alone code describing the technical constituent(s) of the applicable diagnostic test.

## Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding Keystone First Clinical Policies.
VII. Applicable Keystone First manual reference.
VIII. Commonwealth of Pennsylvania Medicaid Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

## Attachments

N/A

## Associated Policies

N/A

## Policy History

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| 10/2025 | Reimbursement Policy Committee Approval |

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| 09/2025 | Annual update<br>• Updated to biennial review |
| 06/2025 | Minor updates to formatting and syntax |
| 04/2025 | Revised preamble |
| 04/2024 | Revised preamble |
| 03/2024 | Reimbursement Policy Committee Approval |
| 08/2023 | Policy implemented by Keystone First removed from Policy History section |
| 01/2023 | Template revised:<br>• Preamble revised<br>• Applicable Claim Types table removed<br>• Coding section renamed to Reimbursement Guidelines<br>• Associated Policies section added |