Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-015		
Subject:	Professional and Technical Components for Applicable Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	March 3, 2025	**Revised Date:**	March 2025
Date Reviewed:	February 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Certain services (e.g., radiology tests, diagnostic medical procedures) include a distinct technical component (modifier TC), consisting of equipment and technical personnel costs. There is also a professional component (modifier 26), which represents the interpretation of test results by the professional provider/physician.

COMMERCIAL REIMBURSEMENT GUIDELINES:

When both the technical and professional components of a procedure are performed by the same professional provider in a setting other than inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, a single charge should be reported for the total procedure.

If a “total charge” procedure is reported inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, payment to the professional provider will be limited to the interpretation or professional component (modifier 26). Any technical costs (modifier TC) incurred for a procedure performed in a facility setting are reimbursed to the facility.

Separate payment can be made for the technical and professional components of a procedure when each is performed by different professional providers (e.g., the doctor who owns the equipment reports only the technical component; the interpreting doctor reports only the professional component). Each provider should report the procedure code with appropriate modifier to reflect the actual services performed (modifier - 26 for professional component; modifier - TC for technical component).

All services must be performed and reported by eligible professional providers.

Note: Delaware Ambulatory Surgery Centers (ASCs) are considered outside the scope of this reimbursement policy.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Payment can be made for the professional component of diagnostic services furnished by a physician to an individual patient in all settings regardless of the specialty of the physician who performs the service.

Payment can be made for the technical component of radiology services furnished to members who are not patients of any hospital, and who receive services in a physician's office, a freestanding imaging or radiation oncology center, or other setting that is not part of a hospital.

Payment cannot be made for the technical component of diagnostic services furnished to a hospital or skilled nursing facility (SNF).

DEFINITIONS:

Modifier	Definition
26	Professional component
TC	Technical component

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-27: Eligible Providers

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed
- RP-035: Correct Coding Guidelines

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Providers will report on the claim, the date of service in which the service was provided. For instance, if a professional service (26 modifier) is being reported, the date of service reported on the claim should be the date in which that professional component was provided, not the date in which the technical component was administered.

REFERENCES:

- CMS Online Manual Pub. 100-04, Chapter 13, Sections 20.1, 20.2, 20.2.1, 20.2.2 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf

POLICY UPDATE HISTORY INFORMATION:

11 / 2017	Implementation
4 / 2020	Added additional billing information
10 / 2020	Added exception note for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
7 / 2023	Removed PHE exception note for codes 99000 and 99001
3 / 2025	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP-015		
Subject:	Professional and Technical Components for Applicable Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	July 10, 2023	**Revised Date:**	July 2023
Date Reviewed:	May 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

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Reference: CMS Online Manual Pub. 100-04, Chapter 13, Sections 20.1, 20.2, 20.2.1, 20.2.2

DEFINITIONS:

Modifier	Definition
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POLICY UPDATE HISTORY INFORMATION:

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11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
7 / 2023	Removed PHE exception note for codes 99000 and 99001

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-015		
Subject:	Professional and Technical Components for Applicable Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

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All services must be performed and reported by eligible professional providers.

Note: Delaware Ambulatory Surgery Centers (ASCs) are considered outside the scope of this reimbursement policy.

Note: As 99000 and 99001 are not diagnostic services, the terms of this policy will not apply to those codes in order to assist with the Public Health Emergency declared by the Department of Health and Human Services (HHS). This exception payment will remain in place until the PHE expires.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

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Reference: CMS Online Manual Pub. 100-04, Chapter 13, Sections 20.1, 20.2, 20.2.1, 20.2.2

DEFINITIONS:

Modifier 26: Professional Component

Modifier TC: Technical Component

RELATED MEDICAL POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-27: Eligible Providers and Supervision Guidelines

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

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POLICY UPDATE HISTORY INFORMATION:

11 / 2017	Implementation
4 / 2020	Added additional billing information
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP- 015		
Subject:	Professional and Technical Components for Applicable Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Certain services (e.g., radiology tests, diagnostic medical procedures) include a distinct technical component (modifier TC), consisting of equipment and technical personnel costs. There is also a professional component (modifier 26), which represents the interpretation of test results by the professional provider/physician.

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Payment cannot be made for the technical component of diagnostic services furnished to a hospital or skilled nursing facility (SNF).

Reference: CMS Online Manual Pub. 100-04, Chapter 13, Sections 20.1, 20.2, 20.2.1, 20.2.2

DEFINITIONS:

Modifier 26: Professional Component

Modifier TC: Technical Component

RELATED MEDICAL POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-27: Eligible Providers and Supervision Guidelines

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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POLICY UPDATE HISTORY INFORMATION:

11 / 2017	Implementation
4 / 2020	Added additional billing information
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-015		
Subject:	Professional and Technical Components for Applicable Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	October 26, 2020	**Revised Date:**	October 2020
Date Reviewed:	October 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Certain services (e.g., radiology tests, diagnostic medical procedures) include a distinct technical component (modifier TC), consisting of equipment and technical personnel costs. There is also a professional component (modifier 26), which represents the interpretation of test results by the professional provider/physician.

DEFINITIONS:

Modifier 26 – Professional Component

Modifier TC – Technical Component

REIMBURSEMENT GUIDELINES:

Commercial Guidelines

When both the technical and professional components of a procedure are performed by the same professional provider in a setting other than inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, a single charge should be reported for the total procedure.

If a "total charge" procedure is reported inpatient hospital, outpatient hospital, skilled nursing facility, or in an ambulatory surgical center, payment to the professional provider will be limited to the interpretation or

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Note: As 99000 and 99001 are not diagnostic services, the terms of this policy will not apply to those codes in order to assist with the Public Health Emergency declared by the Department of Health and Human Services (HHS). This exception payment will remain in place until the PHE expires.

Medicare Advantage Guidelines

Payment can be made for the professional component of diagnostic services furnished by a physician to an individual patient in all settings regardless of the specialty of the physician who performs the service.

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Reference: CMS Online Manual Pub. 100-04, Chapter 13, Sections 20.1, 20.2, 20.2.1, 20.2.2

RELATED MEDICAL POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Z-27: Eligible Providers and Supervision Guidelines

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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POLICY UPDATE HISTORY INFORMATION:

11 / 2017	Implementation
4 / 2020	Added additional billing information
10 / 2020	Added notification exception for codes 99000 and 99001 regarding PHE

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-015		
Subject:	Professional and Technical Components for Applicable Services		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	April 27, 2020	**Revised Date:**	April 2020
Date Reviewed:	April 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	
Applicable Claim Type	**UB**	☐	**1500**	☒	

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REIMBURSEMENT GUIDELINES:

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DEFINITIONS:

Modifier 26 – Professional Component

Modifier TC – Technical Component

RELATED MEDICAL POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Medical Policy: Z-27 Eligible Providers and Supervision Guidelines

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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