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Reimbursement Policy

Title: Professional and Technical Components for Applicable Services

Policy Number: RP-015
Version Number: 2026.08.31

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	August 31, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	October 1, 2017
Claim Type:	CMS 1500	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

This policy provides direction ensuring accurate and appropriate claims processing in accordance with industry standards. This policy describes the reimbursement methodology for Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) codes based on the Centers for Medicare and Medicaid Services (CMS) Professional Component (PC)/Technical Component (TC) indicators.

Reimbursement Guidelines:

Commercial

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 are considered outside the scope of this reimbursement policy.

Medicare Advantage

Reimbursement 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. Reimbursement 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.

Reimbursement cannot be made for the technical component of diagnostic services furnished to a hospital or skilled nursing facility.

Coding: N/A

Definitions:

Modifier	Definition
26	Professional component
TC	Technical component

References:

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

Related Plan 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

Policy Update History:

7 / 2023	Removed PHE exception note for codes 99000 and 99001
3 / 2025	Administrative policy review with no changes in direction
8 / 2026	Administrative policy review with no changes in direction

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
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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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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.

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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
26	Professional component
TC	Technical component

RELATED 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
- RP-035: Correct Coding Guidelines

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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