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Part B Insider (Multispecialty) Coding Alert

Modifiers: Follow These Modifier 26 Dos and Don'ts to Keep Claims Flowing

Master your professional component claims with these quick tips

Modifiers 26 and TC go together like peanut butter and jelly most of the time. But if you don't have a handle on when you should and shouldn't append modifier 26 (Professional component) to your physician's claims, you could find your claims denied or delayed. Consider the following four Dos and Don'ts to perfect your modifier 26 coding knowledge.

DO: If your provider performed only the interpretation and report for a procedure or service, such as an x-ray, you should bill the service by attaching modifier 26 to the CPT® code. The technologist that performed the x-ray (the technical portion of the service) will usually submit the same CPT® code with modifier TC (Technical component) attached. In other words, the physician bills for his reading and reporting of the x-ray, while the facility bills for the equipment, room, film, and radiologic technician.

Example: A patient sees his family physician with complaints of fever, cough, and shortness of breath. The physician suspects pneumonia and sends the patient to the radiologist for a four-view chest x-ray. The patient brings his films back to his family physician's office, where his physician reads them. The radiology office owns the x-ray equipment, not the family physician's office. The family physician would bill 71030 (Radiologic examination, chest, complete, minimum of 4 views) with modifier 26 and the radiology office would bill 71030 with modifier TC.

Tip: Technical component charges are institutional charges, made by a person or facility which actually owns the equipment, and are not billed separately by physicians.

DON'T: You should not use modifier 26 with procedures that are either 100 percent technical or 100 percent professional. You should use it only on procedures having both components.

For example, if a doctor performs an ECG in the office setting, he would report his service with 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report). If the physician interprets the same test in the hospital, he'll report 93010 (... interpretation and report only). The first code is a complete service code while the second is limited to the physician's interpretation.

Warning: If the physician fails to append modifier 26 and the facility nonetheless bills with modifier TC, the technical portion of the service will have been double-billed, which could lead to accusations of fraud or a demand for repayment from your carrier.

Safeguard: Medicare will not typically pay a physician for the technical component of services provided in a facility setting. In other words, if your claim lists a place of service (POS) as an outpatient hospital (POS 22), this will prevent double-billing from happening.

DO: Check the rules when treating hospital inpatients, even if you're using your personal equipment. When billing Medicare, for instance, physicians providing services in a hospital or facility setting cannot typically claim the technical portion of a procedure regardless of whether they own the equipment.

For instance, if the gastroenterologist orders 24-hour pH testing (91034, Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode[s] placement, recording, analysis and interpretation) on a hospital inpatient using his own machine, he will be required to append modifier 26.

Here's why: Under the diagnosis-related group (DRG), the hospital receives payment for the technical component of

Medicare inpatient services.

A physician can still receive reimbursement for inpatient testing. Although the physician cannot bill the carrier for the technical component under the DRG system, he may either bill the facility or establish a separate contract with it to receive the appropriate reimbursement when necessary. This could apply in cases when the physician:

1. owns the equipment
2. employs the technician who performs the test, or
3. personally performs the test.

DON'T: You must avoid using modifier 26 for a reinterpretation of another physician's x-ray. Suppose the patient gets a chest x-ray elsewhere where it's interpreted by a radiologist, then he brings the chest x-ray back to you for an additional interpretation. In this case, you should not bill for interpretation because the radiologist has already reported it. You should count your doctor's re-read toward the medical decision-making portion of the E/M for that visit.