Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

Split Professional, Technical Components Like A Pro

Purchasing power will change the rules for modifiers 26, TC

Reporting modifiers 26 (Pro-fessional component) and TC (Tech-nical component) may seem like a breeze, but if you forget to apply modifier 26 on your claim when the physician renders the service in a facility setting, you could be setting yourself up for serious double-billing accusations.

Problem: Coders "don't split up the technical and professional components," says **Angela Cook,** patient accounts manager with a physician institute in Lecanto, Fla.

Brush up on your professional, technical component modifier skills and learn what to do when your practice purchases modifier TC.

Draw the Line Between Modifiers

Certain CPT codes, such as those for myocardial perfusion studies (78465, Myocardial perfusion imaging; tomographic [SPECT], multiple studies [including attenuation correction when performed], at rest and/or stress [exercise and/or pharmacologic] and redistribution and/or rest injection, with or without quantification), consist of two components: the technical component (modifier TC) and the professional component (modifier 26).

In other words: "TC is for the entity that owns the equipment," says **Peggy Stilley, CPC,** office manager for an **Oklahoma University**-based private physician practice in Tulsa, "and the 26 is for the professional interpretation."

Break Down Modifier 26

If your physician performs a myocardial perfusion study with a facility's equipment, you should use 78465 and append modifier 26 to reflect that he interpreted the findings and wrote the report.

Keep in mind: 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 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.

Tackle Modifier TC

In the same scenario above, the facility owning the equipment would then report the myocardial perfusion study code 78465 using modifier TC for its portion of the test. Modifier TC indicates to the payer that the facility supplied only the technical component and not the professional interpretation, says **Marvel Hammer, RN, CPC, CHCO,** owner of **MJH**

CPT® 2023 American Medical Association. All rights reserved.

Consulting in Denver.

Global Component May Be OK

If the physician performs both technical and professional components, he should submit a CMS-1500 form with the CPT code and no modifier to indicate he provided the global procedure, Hammer says.

For example, a doctor orders a myocardial perfusion study and interprets and documents the findings. He owns or leases the equipment involved and employs a nuclear tech.

In this scenario, the physician performed the global procedure and would submit the CMS-1500 with code 78465. He will be reimbursed for the entire global relative value unit (RVU) amount.

According to Regence Blue-Cross BlueShield of Oregon, "A 'complete' procedure (that is, professional plus technical component) billed with no modifier attached to the procedure code, is only eligible for reporting and reimbursement when that provider owns the equipment and is also providing the professional component."

You Can Purchase Modifier TC

But suppose that your cardiologist does not have the capability to perform a myocardial perfusion study (or other diagnostic test) in his office.

Instead, he contracts with another physician, medical group, or supplier, such as a mobile imaging lab, to perform the technical component for him."

A provider that does not own the diagnostic equipment or employ the necessary staff may purchase technical and/or professional components from another supplier and potentially receive reimbursement for the global code, Hammer says.

The Medicare Claims Manual 100-04, Chapter 1, 30.2.9 states, "A physician or medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the technical component of diagnostic tests which the physician or group purchases from an independent physician, medical group, or supplier."

Catch: When you purchase the technical component, you have to list the purchasing entity's provider number. Thus, you can deal only with a Medicare-recognized entity.

Avoid 2 Purchased TC Pitfalls

According to MCM Part 3, you should not submit a global code on your claim when your practice purchased one component of the service. You bill it as split-billed. In other words, you use modifier 26 for your own piece and bill the TC as a purchased modifier.

Pitfall #1: Always be sure to indicate when you purchased the technical component. If you don't indicate that you purchased it, you have a potential false claim.

According to Trailblazer Health, you may not submit a global code when your practice purchases one component. You should submit the technical and professional components on separate lines or separate claims depending on how you file them so the carriers can determine payment jurisdiction and price services correctly.

Pitfall #2: If you buy the technical component, you are not allowed to mark up the price. Your charge will be the fee schedule amount or the actual amount you paid, whichever is less.

Prior to reporting for purchased test components, make sure to consult with your attorney about other regulatory concerns before changing any practices.

CPT® 2023 American Medical Association. All rights reserved.

Codify by AAPC

CPT® 2023 American Medical Association. All rights reserved.