Summit COMMUNITY CARE

Arkansas | Medicaid

Reimbursement Policy
Modifiers 26 and TC: Professional and Technical Component

Policy Number: **G-15004**
Policy Section: **Coding**
Last Approval Date: **03/26/2026**
Effective Date: **03/26/2026**

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Policy

The health plan allows reimbursement of the professional component and technical component of a global procedure or service when appended with modifier 26 and modifier TC, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on the following:

- The applicable fee schedule or contracted/negotiated rate
- Physician specialty and the place of service (POS) code submitted with the claim

Professional component (Modifier 26)

The professional component is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service. When reported separately, the professional component is denoted by adding modifier 26 to the applicable procedure code.

Technical component (Modifier TC)

When reported separately, the technical component is denoted by adding the modifier TC to the applicable procedure code. Services or procedures billed by a physician or other qualified healthcare professional that are performed in a facility place of service, as defined in the Related Coding section below, will not be reimbursed for the global procedure or the technical component.

Only the facility may be reimbursed for the technical component of the service or procedure.

The physician or other qualified healthcare professional may be reimbursed only for the professional component of the service or procedure and, if applicable, should make an arrangement with the facility for reimbursement to perform any technical components of a service or procedure.

Portable X-ray suppliers should bill only for the technical component by appending modifier TC.

Global procedure

In the absence of modifier TC and modifier 26, the health plan will allow reimbursement of the global procedure if the same physician or other qualified health care professional performed both the professional component and technical component of that service.

Nonreimbursable

The health plan does not allow reimbursement for the use of modifier 26 or modifier TC when it is reported on an Evaluation and Management (E/M) code.

The health plan reserves the right to perform post-payment review of claims submitted with modifier 26 or modifier TC. The health plan may request additional documentation or notify the provider of additional documentation required for claims, subject to contractual obligations. If documentation is not provided following the request or notification, the health plan may recoup or recover monies previously paid on the claim, as the provider failed to submit required documentation for post-payment review.

Related Coding

- Place of service 19 — Off Campus — Outpatient Hospital:
  - Defines facilities within the context of this policy.
  - The global procedure or technical component will not be reimbursed to a physician in this place of service
- Place of Service 21 — Inpatient Hospital:
  - Defines facilities within the context of this policy.
  - The global procedure or technical component will not be reimbursed to a physician in this place of service.
- Place of Service 22 — On Campus-Outpatient Hospital:
  - Defines facilities within the context of this policy.
  - The global procedure or technical component will not be reimbursed to a physician in this place of service.
- Place of Service 23 — Emergency Room — Hospital:
  - Defines facilities within the context of this policy.
  - The global procedure or technical component will not be reimbursed to a physician in this place of service.
- Place of Service 24 — Ambulatory Surgical Center:
  - Defines facilities within the context of this policy.
  - The global procedure or technical component will not be reimbursed to a physician in this place of service.
- Place of Service 51 — Inpatient Psychiatric Facility:
  - Defines facilities within the context of this policy.
  - The global procedure or technical component will not be reimbursed to a physician in this place of service.
- Place of Service 61 — Comprehensive Inpatient Rehabilitation Facility:
  - Defines facilities within the context of this policy.

- The global procedure or technical component will not be reimbursed to a physician in this place of service.

Definitions

- **Global Procedure:** Represents both the professional and technical component as a complete procedure or service. Identified by reporting the eligible procedure without modifier 26 or TC.
- **Professional Component (Modifier 26):** Professional Component. Portion of a charge for healthcare services represents the physician's (or other practitioner's) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges. Certain procedures are a combination of a physician or other qualified healthcare professional component and a technical component. When the physician or other qualified healthcare professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
- **Standalone Code:** Describes the professional component only, technical component only, or global test only of a selected diagnostic test. Modifier 26 or TC should not be used with a standalone code.
- **Technical Component (Modifier TC):** Technical component. Portion of a healthcare service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services. Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable X-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable X-ray suppliers will then be used to build customary and prevailing profiles.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Documentation Standards for Episodes of Care
- Modifier Usage
- Multiple Radiology Payment Reduction
- Portable/Mobile/Handheld Radiology Services

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2026
- State contract
- State Medicaid

Policy History

- **03/26/2026 -** Review approved and effective: updated policy title from Modifiers 26 and TC
- **10/30/2023 -** Review approved and effective: removed Professional and Technical Component from policy title; updated comments in Related Coding section; updated modifiers 26 and TC in Definitions section
- **07/13/2020 -** Review approved: policy language updated to remove definitions from the policy body; minor administrative updates
- **03/01/2019 -** Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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