

## Professional/Technical Component Policy, Professional

### IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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**Application**

**This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid Product.**

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

**Policy**

**Overview**

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) National Physician Fee Schedule (NPFS) Relative Value File, Professional Component (PC)/Technical Component (TC) Indicators.

<b>NPFS PC/TC Indicator</b>	<b>Description</b>
0	Physician Service Codes
1	Diagnostic Tests
2	Professional Component Only Codes
3	Technical Component Only Codes
4	Global Test Only Codes
5	Incident To Codes
6	Laboratory Physician Interpretation Codes
7	Physical therapy service, for which payment may not be made
8	Physician interpretation codes
9	Not Applicable

Relative to these services, this policy also addresses information pertaining to Duplicate or Repeat Services, modifier usage, submissions based on place of service (POS), and the Professional Component with an Evaluation and Management service.

Unless otherwise specified, for the purposes of this policy, Same Individual Physician or Other Qualified Health Care Professional is defined as the same individual rendering health care services reporting the same Federal Tax Identification number.

**Reimbursement Guidelines**

**UnitedHealthcare Community Plan Professional/Technical Splits**

UnitedHealthcare Community Plan uses the Center for Medicare and Medicaid Services' (CMS) PC/TC indicators as set forth in the "CMS Payment Policies" under the NPFS to determine whether a CPT or HCPCS procedure code is eligible for separate professional and technical services reimbursement.

CPT or HCPCS codes assigned a CMS PC/TC Indicator 1 are comprised of a Professional Component and a Technical Component which together constitute the Global Service. The Professional Component (PC), (supervision and interpretation) is reported with modifier 26, and the Technical Component (TC) is reported with modifier TC.

The term "professional/technical split" is used to reference a Global Service assigned a PC/TC Indicator 1 that may be "split" into a Professional and Technical Component. CPT or HCPCS codes assigned a PC/TC Indicator 1 are listed in the NPFS. Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component, and Professional Component.

CPT or HCPCS codes with CMS PC/TC Indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with modifiers 26 and/or TC. Codes with Indicator 6 are not considered eligible for reimbursement when submitted with modifier TC.

CMS publishes this information in the "Physician Fee Schedule, PFS Relative Value Files" page, accessible through the following website:

[Physician Fee Schedule Relative Value Files](#)

UnitedHealthcare Community Plan's percentage splits are developed on a national level from the CMS **Non-Facility Total** Resource Based Relative Value Scale (RBRVS) based percentage splits. UnitedHealthcare Community Plan's splits are updated quarterly and differ no more than 2.5% (for each CPT and HCPCS code) from the CMS **Non-Facility Total** RBRVS based percentage splits which are found in the NPFS. The current splits are attached to this policy in the next section.

Services assigned a PC/TC Indicator 1 that CMS indicates may be carrier-priced, or those for which CMS does not develop RVUs are considered Gap Fill Codes.  
 Codes.

When data is available for Gap Fill Codes, UnitedHealthcare Community Plan uses the relative values published in the first quarter update of the Optum *The Essential RBRVS* publication for the current calendar year.

[UnitedHealthcare Community Plan Professional Technical Component Policy Gap Fill Codes](#)

Gap Fill Codes that are eligible for PC/TC per CMS but do not have RVUs established, or data available for gap fill, are included in the "Codes Subject to the CMS PC/TC Concept Without RVU Splits" list below and are allowed at 100% of the Allowable Amount for both the Professional Component and Technical Component.

**UnitedHealthcare Community Plan Codes Subject to the PC/TC Concept Without RVU Splits**

0506T	0528T	0529T	0533T	0534T	0535T	0536T	0633T	0634T	0635T
0636T	0637T	0638T	0648T	0649T	650T	75956	75957	75958	75959
76499	76998	76999	77299	77399	77499	77799	78099	78199	78299
78399	78499	78599	78609	78699	78799	78999	79999	88199	88399
91299	92499	93799	93895	94799	96020	G0219	G0235	G0252	G0255

For additional information refer to the [Questions and Answers](#) section, Q&A #1.

**Reimbursement Amounts for Professional/Technical Splits**

The Professional and Technical Component reimbursement for PC/TC split eligible services is calculated at a percentage of the Global Service Allowable Amount, except when provided otherwise by a physician or other qualified health care professional contract. When a contract applies, payments for PC/TC split eligible services are based on specific professional and technical fees contained within the contract's fee schedules or are paid at the percentage of charge level in the fee schedule.

[UnitedHealthcare Community Plan Professional/Technical Component Split Codes \(PC/TC Indicator 1 Diagnostic Tests\)](#)

When eligible for reimbursement, Professional/Technical Component codes with a CMS PC/TC Indicator 2, 3, 4, 5, 6, or 8 are reimbursed at 100% of the Allowable Amount.

For additional information, refer to the [Questions and Answers](#) section, Q&A #2.

**Reimbursement for Professional/Technical Component Based on POS**

Reimbursement of the Professional Component, the Technical Component, and the Global Service for codes assigned a PC/TC Indicator 1, 2, 3, 4, 5, 6, 8 or 9 subject to the PC/TC concept according to the NPFS are based upon physician and other qualified health care professional specialty and CMS POS code set, as described below.

[CMS POS Code Set](#)

The edits administered by this policy may be found on the following link using the appropriate year and quarter referencing the "PCTC IND" column:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

For the purposes of this policy, a facility POS is considered POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 and 61. All other POS are considered non-facility.

### Facility

#### For Services Furnished in a Facility (POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61)

Any services that are provided in a facility POS and that are subject to the PC/TC concept or that have both a Professional Component and a Technical Component according to the CMS PC/TC indicators, UnitedHealthcare Community Plan will reimburse the interpreting physician or other qualified health care professional only the Professional Component as the facility is reimbursed for the Technical Component of the service. To be considered for Professional Component reimbursement, a service or procedure must have a:

- CMS PC/TC Indicator 1, and must be reported with modifier 26;
- CMS PC/TC Indicator 2 (Professional Component Only Codes), and must be reported without modifier 26 or TC; or
- CMS PC/TC Indicator 6 (Laboratory Physician Interpretation Codes) and must be reported with modifier 26.
- CMS PC/TC Indicator 8 (Physician Interpretation Codes), and be reported without modifier 26

When a physician or other qualified health care professional provides the equipment to perform the service or procedure in a facility POS only the facility may be reimbursed for the Technical Component of the service or procedure. Based on the CMS PC/TC indicators, UnitedHealthcare Community Plan considers the Technical Component to be a service or procedure that has a:

- CMS PC/TC Indicator 1 (Diagnostic Test), and is reported with modifier TC; or
- CMS PC/TC Indicator 3 (Technical Component Only Codes), and is reported without modifier TC.

#### For PC/TC Indicator 8 Codes Furnished in a POS Other than POS 21

The CMS NPFS guidelines advise that payment should not be recognized for PC/TC Indicator 8 codes, which are defined as physician interpretation codes, furnished to patients in the outpatient or non-hospital setting (POS other than 21).

In alignment with CMS, UnitedHealthcare Community Plan will not reimburse PC/TC Indicator 8 (CPT code 85060) when reported by a physician or other qualified health care professional with a CMS POS code other than inpatient hospital (POS 21).

#### Non-Allowed Services Furnished in a Facility POS

Consistent with CMS, UnitedHealthcare Community Plan will not allow reimbursement to physicians and other qualified health care professionals for "Incident To" codes identified with a CMS PC/TC Indicator 5 when reported in a facility POS regardless of whether a modifier is reported with the code. In addition, CPT coding guidelines for many of the PC/TC Indicator 5 codes specify that these codes are not intended to be reported by a physician in a facility setting.

UnitedHealthcare Community Plan will not reimburse physicians or other qualified health care professionals for services with a CMS PC/TC Indicator 4 (stand-alone Global Test Only Codes), when rendered in a facility POS. Codes with a PC/TC Indicator 4 identify Stand-alone Codes that describe selected diagnostic tests for which there are separate associated codes that depict the Professional Component only (PC/TC Indicator 2) and Technical Component only (PC/TC Indicator 3).

UnitedHealthcare Community Plan utilizes the CMS National Physician Fee Schedule (NPFS) PC/TC Indicators 3 or 9 to identify laboratory services that are not reimbursable to a Reference Laboratory or Non-Reference Laboratory in a facility setting.

UnitedHealthcare Community Plan will not reimburse a Professional Component when a diagnostic laboratory service is provided either manually or with automated equipment, as these codes are not subject to the PC/TC concept or are

Technical Component only codes. UnitedHealthcare Community Plan follows CMS PC/TC indicators in determining which services do not qualify for Professional Component reimbursement:

- CMS PC/TC Indicator 3 (Technical Component Only Codes)
- CMS PC/TC Indicator 9 (PC/TC Concept Not Applicable)

[UnitedHealthcare Community Plan Laboratory Codes with a \(PC/TC Indicator 3 or 9 Diagnostic Tests\)](#)

Note: UnitedHealthcare Community Plan will make an exception to this policy for reproductive medicine procedures 89250-89398 when the facility laboratory is not equipped to perform these specialized services and refers them to a reproductive laboratory. In the event that both a facility and a Reference Laboratory report the same service on the same day for the same member, only the facility laboratory may be reimbursed.

**Non-Facility**

For Services Furnished in a Non-Facility POS (POS other than 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61)

For services assigned a PC/TC Indicator 1 according to CMS, and provided in a non-facility POS, UnitedHealthcare Community Plan will consider reimbursement of the Professional Component and the Technical Component when eligible.

For Services Furnished in a Mobile Unit

Services furnished in a mobile unit are often provided to serve an entity for which another POS code exists. When this is the case, the POS for that entity should be reported. For example, a mobile unit may be sent to a facility. Since the mobile unit is serving an entity for which a facility POS already exists, the POS code 21 (inpatient hospital) for that location should be reported. However, if the mobile unit is not serving an entity which could be described by an existing POS code, report POS 15 (mobile unit).

Note: When intraoperative neuromonitoring (IONM) services (95940 and G0453) and associated study codes are reported in a facility POS, the Technical Component will be denied.

**Services Reported in a CMS POS 24 (Ambulatory Surgical Center)**

Consistent with CMS guidelines, UnitedHealthcare Community Plan will not reimburse physicians or other qualified health care professionals for the Technical Component of services included in the Ambulatory Surgery Center Fee Schedule (ASCFS) Addendum BB and reported with a CMS POS 24 as the ambulatory surgical center (ASC) is reimbursed for the Technical Component.

The Technical Component of services reported on a CM-1500 claim form with an SG modifier (Ambulatory surgical center [ASC] facility service) is not reimbursed as a professional claim. Claim lines reported with modifier SG indicate a facility charge and are reimbursed as a facility claim.

**PC/TC Indicator 1 Codes**

For codes included in the ASCFS Addendum BB PC/TC Indicator 1 Codes list, only the Professional Component (PC, modifier 26) will be reimbursed.

- When reported globally (no modifier), the Technical Component of the code will not be reimbursed.
- When reported with modifier TC, the code will not be reimbursed.
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[UnitedHealthcare Community Plan ASCFS Addendum BB PC/TC Indicator 1 Codes](#)

**PC/TC Indicator 3 Codes**

Codes included in the ASCFS Addendum BB PC/TC Indicator 3 Codes list will not be reimbursed as they represent Technical Component services only.

**UnitedHealthcare Community Plan ASCFS Addendum BB PC/TC Indicator 3 Codes**

77336	77370	77385	77386	77401	77402	77407	77412	77417	77423
77520	77522	77523	77525	77790					



**Drug Administration Codes**

According to the CMS National Correct Coding Initiative (NCCI) Policy Manual, drug administration codes CPT 96360-96379, 96401-96425, and 96521-96523 are considered included in the facility payment when reported in POS 24.

In alignment with CMS, UnitedHealthcare Community Plan will not reimburse drug administration codes 96360-96379, 96401-96425, and 96521-96523 reported by a physician or other qualified health care professional in POS 24.

**Drug Administration Codes**

96360	96361	96365	96366	96367	96368	96370	96371	96372	96373
96374	96375	96376	96379	96401	96402	96405	96406	96409	96411
96413	96415	96416	96417	96420	96425	96521	96522	96523	

**Duplicate or Repeat Services for Professional/Technical Eligible Codes**

This section of the policy applies to when Duplicate or Repeat Services are reported by the same or different physician or other qualified health care professional. When services are eligible for reimbursement under this policy, only one physician or other qualified health care professional will be reimbursed when Duplicate or Repeat Services are reported. Duplicate or Repeat Services are defined as identical CPT or HCPCS codes assigned a PC/TC Indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient for the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.

For services that have both a Professional and Technical Component reported separately, UnitedHealthcare Community Plan will also review the submission of modifier 26 and TC appended to the code(s) to identify whether a Duplicate or Repeat Services has been reported.

Should the Same Individual Physician or Other Qualified Health Care Professional report the Professional Component (modifier 26) and the Technical Component (modifier TC) for the same PC/TC Indicator 1 service separately, UnitedHealthcare Community Plan will consider both services eligible for reimbursement unless subject to other portions of this policy.

Modifiers offer specific information and should be used appropriately. Separate consideration will be given to duplicate or repeat multiple submissions of the same code when the appropriate modifier is appended to the Duplicate or Repeat Service with one of the following modifiers:

**Modifiers**

59	76	77	91	E1	E2	E3	E4	FA	F1
F2	F3	F4	F5	F6	F7	F8	F9	LC	LD
LM	LT	RC	RI	RT	TA	T1	T2	T3	T4
T5	T6	T7	T8	T9	XE	XP	XS	XU	

For additional information, refer to the [Questions and Answers](#) section, Q&A #3.

UnitedHealthcare Community Plan follows a "first in, first out" claim payment methodology in determining which claim will be considered for reimbursement when claims for Duplicate or Repeat Services are received.

- When the Same Individual Physician or Other Qualified Health Care Professional reports the Global Service (PC/TC Indicator 1):
  - or a stand-alone service (PC/TC Indicator 2, 3, or 4) more than once and on separate lines, separate consideration will only be given to those services reported with the appropriate modifier. Otherwise, the second and subsequent services received will not be separately reimbursed.
  - and a modifier 26 or TC for the same service for the same member on the same date of service, separate consideration will only be given to those services reported with the appropriate modifier. Otherwise, the second and subsequent services will not be separately reimbursed.
- When the same PC/TC Indicator 6 or 8 service is reported more than once and on separate lines by the same or different physician or qualified health care professional, separate consideration will only be given to those

services reported with modifier 59, XE, XP, XS, XU or 91. Otherwise the second and subsequent services received will not be separately reimbursed.

- When the same Global Service (PC/TC Indicator 1) service is reported globally (no modifier) by different physicians or other qualified health care professionals on the same date or service for the same member, UnitedHealthcare Community Plan will only consider separate reimbursement for the second claim when reported with an appropriate modifier. Otherwise, the second and subsequent services received will not be separately reimbursed.
- When the same Global Service (PC/TC Indicator 1) service is reported globally by one physician or other qualified health care professional, and a different physician or other qualified health care professional reports modifier 26 or TC for the same service for the same member on the same date of service, UnitedHealthcare Community Plan will consider separate reimbursement for the second claim when reported with an appropriate modifier. Otherwise, the second and subsequent services will not be separately reimbursed.
- When a PC/TC 4 service is billed with a PC/TC 2 or 3 service for the same member, same date of service, and by the same or different provider; then the second and subsequent service billed will be denied unless billed with an appropriate modifier.

For example:

- If the claim for the physician reporting the Global Service is received first and allowed, the subsequent claim received by a different physician for a single component (i.e., Professional or Technical Component) will be denied as duplicate.
- If the claim for the physician reporting the Professional Component (modifier 26) service is received first and allowed, the subsequent claim received by a different physician for the Global Service will be reimbursed only for the Technical Component.
- If the claim for the physician reporting the Technical Component (modifier TC) service is received first and allowed, the subsequent claim received by a different physician for the Global Service will be reimbursed only for the Professional Component.

Refer to the UnitedHealthcare Community Plan "Laboratory Services Policy" for additional information on duplicate charges for laboratory services. Refer to the UnitedHealthcare Community Plan "Maximum Frequency per Day Policy" for additional information on assigned MFD values.

### Professional Component with an Evaluation and Management Service

With the exception of radiologic codes that describe fluoroscopic or ultrasonic guidance for placement of a needle, catheter, or tube, UnitedHealthcare Community Plan considers the interpretation (modifier 26) of a radiology service assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service for the same patient as these services usually are not distinct from the E/M service when both are provided on the same day.

American College of Radiology (ACR) guidelines suggest that physicians and other qualified health care professionals who believe the Professional Component (modifier 26) for a PC/TC Indicator 1 radiology code is reimbursable in addition to the E/M service on the same day include the following information in the medical record:

#### Procedures and materials

- The report or record should include a description of the studies and/or procedures performed and any contrast media and/or radio-pharmaceuticals (including specific administered activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere.

#### Findings

- The report or record should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings.

#### Impression

- Conclusion or diagnosis

### State Exceptions

#### All Medicaid Lines of Business

Codes 90471 and 90472 are allowed in a facility place of service.

<b>California</b>	Medicaid allows the PC/TC Modifiers on HCPC codes Q0111, Q0112 and Q0113.
<b>Kansas</b>	Per State Regulations: <ul style="list-style-type: none"> <li>CPT codes 92586 and 92587 are reimbursable in a facility place of service (POS 19, 21, 22, 23, 24, 26, 34, 51, 52, 55, 56, 57 or 61). Place of service 21 is not reimbursable for newborns during the date span of the delivery hospital stay.</li> <li>CPT code 59025 is reimbursable in POS 22.</li> </ul>
<b>Kentucky</b>	Per state regulation, CPT codes 88300-88399 and 89250-89356 are excluded from PC/TC editing for Kentucky.
<b>Mississippi</b>	Per state regulation, MSCAN and MSCHIP allow reimbursement for codes 96160 and 96161 when submitted with Modifier EP in a facility place of service Per state regulation, MSCAN allows reimbursement for 94640 in POS 22 AND 19.
<b>Ohio</b>	OH Medicaid and MMP products allows professional providers to be reimbursed for 36415, 81025 QW, 82075, and 86580 in a place of service 55 and 36415, 81025 QW, 82075, 86580, and 96372 in a place of service 57
<b>Washington</b>	Per state regulation, WA allows H0003 in a facility Place of service Washington Medicaid allows reimbursement for CPT 92586 in a Place of Service 21.
<b>Wisconsin</b>	Per state regulation, WI considers place of service 19 as a non-facility and allows code H0049

<b>Definitions</b>	
<b>Allowable Amount</b>	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
<b>Duplicate or Repeat Services</b>	Identical CPT or HCPCS codes assigned a PC/TC indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.
<b>Gap Fill Code</b>	Codes for which CMS does not develop RVUs. Relative values are therefore assigned based on the first quarter update of Optum The Essential RBRVS publication for the current calendar year.
<b>Global Service</b>	A Global Service includes both a Professional Component and a Technical Component. When a physician or other qualified health care professional bills a Global Service, he or she is submitting for both the Professional Component and the Technical Component of that code. Submission of a Global Service asserts that the Same Individual Physician or Other Qualified Health Care Professional provided the supervision, interpretation and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. In appropriate circumstances, the Global Service is identified by reporting the appropriate PC/TC split eligible procedure code with no modifier attached or by reporting a Stand-alone code for global test only services.
<b>Independent Laboratory</b>	An Independent Laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital. An independent laboratory must meet Federal and State requirements for certification and proficiency testing under the Clinical Laboratories Improvement Act (CLIA).



<b>Non-Reference Laboratory</b>	A physician or a Pathologist reporting laboratory procedures performed in their office
<b>Pathologist</b>	A Pathologist is a physician who specializes in diagnosing diseases by examining tissue, blood, and body fluids using advanced laboratory techniques.
<b>Professional Component</b>	The Professional Component represents the physician or other qualified health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other qualified health care professional supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative report to be included in the patient's medical record, and directly contributes to the patient's diagnosis and/or treatment. In appropriate circumstances, it is identified by appending modifier 26 to the designated procedure code or by reporting a Stand-alone code that describes the Professional Component only of a selected diagnostic test.
<b>Reference Laboratory</b>	A Reference Laboratory that receives a Specimen from another, Referring Laboratory for testing and that actually performs the test is often referred to as an Independent Laboratory.
<b>Relative Value Unit (RVU)</b>	The assigned unit value of a particular CPT or HCPCS code. The associated RVU is from CMS NPFS Non-Facility Total value.
<b>Resource-Based Relative Value Scale (RBRVS)</b>	Payment schedule based on the relative values of services provided. The current RBRVS system ranks services according to the relative costs required to provide them. These costs are defined in terms of units, with more complex, more time consuming services having higher unit values than less complex, less time-consuming services. Furthermore, each service is compared to all other physician services so that each service is given a value that reflects its cost or value when compared to all other physician services.
<b>Same Individual Physician or Other Qualified Health Care Professional</b>	The same individual rendering health care services reporting the same Federal Tax Identification number.
<b>Specimen</b>	Tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathological diagnosis. Two or more such Specimens from the same patient (eg, separately identifiable endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.
<b>Stand-alone Code</b>	A Stand-alone Code describes a specific component of a selected diagnostic test. There is an associated code that describes the Professional Component only of the diagnostic test, an associated code that describes the Technical Component only, and another associated code that describes the global test only. An example is the series of codes used to describe electrocardiograms with at least 12 leads. CPT code 93010 describes the Professional Component only, 93005 describes the Technical Component only, and 93000 describes the global test only. Modifiers TC or 26 are not used to report these services as they are inherent within the code descriptions.
<b>Technical Component</b>	The Technical Component is the performance (technician/equipment/facility) of the procedure. In appropriate circumstances, it is identified by appending modifier TC to the designated procedure code or by reporting a Stand-alone Code that describes the Technical Component only of a selected diagnostic test.

### Questions and Answers



1

**Q:** Are the CMS Geographic Practice Cost Indices by Medicare Carrier and Locality considered when developing UnitedHealthcare Community Plan percentage splits?



**A:** No. The UnitedHealthcare Community Plan percentage splits are developed on a national level from the CMS Resource Based Relative Value Scale (RBRVS) percentage splits.

2	<p><b>Q:</b> If a physician or other qualified health care professional is contracted with specific rates for the Professional Component and the Technical Component, will their contracted rates be updated quarterly to reflect changes in CMS professional and technical rates?</p> <p><b>A:</b> No. As their fees for the Professional Component and the Technical Component are determined by their contract, the physician or other qualified health care professional will not be impacted by UnitedHealthcare Community Plan's quarterly updates to the percentage calculation methodology for Professional Component and Technical Component reimbursement.</p>
3	<p><b>Q:</b> When does UnitedHealthcare Community Plan give consideration for repeat procedures by the same individual physician, another physician or other qualified health care professional when reported with modifiers 76 or 77?</p> <p><b>A:</b> Repeat procedures must be identified with modifiers 76 or 77 as appropriate to indicate that subsequent procedures were performed at different episodes on the same day. Modifiers 76 or 77 should not be used to report multiple interpretations by the same or different physicians or other qualified health care professionals for the same EKG or x-ray procedure for quality control purposes. However, when subsequent interpretations of the same procedure show a different finding that alters/contributes to the diagnosis and treatment of the patient, use of modifier 76 or 77 is appropriate.</p> <p>Note: It is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services. Modifiers 59, XE, XP, XS or XU or 91 should be used to indicate repeat or distinct laboratory services, as appropriate according to the AMA and CMS. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77.</p>
4	<p><b>Q:</b> There is a series of electrocardiogram CPT codes where one code describes the Professional Component only of the diagnostic test (e.g. CPT code 93010; PCTC Indicator = 2), an associated code that describes the Technical Component only (e.g. CPT code 93005; PCTC Indicator = 3), and another associated code that describes the global tests only (e.g. CPT code 93000; PCTC Indicator = 4). Does duplicate editing apply to this code series?</p> <p><b>A:</b> Yes. Modifiers 26 or TC are not used to report these services as the intent is inherent within the code descriptions. If the global test is received first, then the component code(s) will be denied. If a component code is received first, then the global test will be denied.</p>
5	<p><b>Q:</b> When a patient is in an outpatient or inpatient hospital setting and a mobile unit furnishes a service in conjunction with the hospital service, what place of service may the mobile unit report?</p> <p><b>A:</b> When a mobile unit is serving an entity for which a facility POS already exists, certain services should be reported with POS 15 only if a facility claim has not been submitted or received for the same date of service. Services with a technical component performed in a facility setting are deemed included in the global payment to the facility and are not separately reimbursable when reported by a physician or other qualified health care professional.</p>

#### Attachments

 <p><b>Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests)</b></p>	<p>A list of codes with a CMS PC/TC Indicator 1 with their percentage splits. These codes have both a Professional Component and a Technical Component. Modifiers 26 and TC can be used with these codes.</p>
 <p><b>Gap Fill Codes</b></p>	<p>A list of PC/TC Indicator 1 Diagnostic Test codes subject to the CMS PC/TC component concept, for which CMS does not develop RVUs or which CMS states may be carrier-based. These are assigned gap fill RVUs from data published by CMS Carriers or are otherwise assigned RVUs by UnitedHealthcare Community Plan.</p>

**Attachments**

 <b>Laboratory Codes with a PC/TC Indicator 3 or 9</b>	<p>A list of codes that have been assigned a PC/TC Indicator of 3 or 9.</p> <p><b>PC/TC Indicator 3:</b> Technical Component Only Code</p> <p><b>PC/TC Indicator 9:</b> The concept of a PC/TC component does not apply. These services are not reimbursable when submitted with the Professional Component (modifier 26).</p>
 <b>ASCFS Addendum BB PC/TC Indicator 1 Codes</b>	<p>A list of codes with a PC/TC Indicator 1 that when reported in a CMS POS 24 (ambulatory surgical center), only the Professional Component (modifier 26, PC) will be reimbursed.</p>

**Resources**

Individual state Medicaid regulations, manuals & fee schedules

American College of Radiology – ACR Practice Guideline for Communication of Diagnostic Imaging Findings  
<http://www.acr.org/Quality-Safety/Standards-Guidelines/Practice-Guidelines-by-Modality>

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

Optum, "The Essential RBRVS," 1st Quarter Update

**History**

<b>7/11/2021</b>	Policy Version Change Policy List Change: ASCFS Addendum BB PC/TC Indicator 1 Codes
<b>6/27/2021</b>	Policy Version Change Policy List Changes: Codes Subject to the PC/TC Concept Without RVU Splits; Laboratory Codes with a PC/TC Indicator 3 or 9 History Section: Entries prior to 6/25/2019 archived
<b>5/28/2021</b>	Policy Version Change Attachments Section: Removed attachment(s) and converted to table(s) or supplied link to the CMS NPFS. Policy Section Change: Reimbursement for Professional Technical Component Based on POS and Duplicate or Repeat Services for Professional/Technical Eligible Codes History Section: Entries prior to 5/3/2019 archived
<b>2/14/2021</b>	Policy Version Change Policy List Changes: Laboratory Codes with a PC/TC Indicator 3 or 9
<b>2/7/2021</b>	Policy Version Change Policy List Changes: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Codes Subject to the PC/TC Concept Without RVU Splits
<b>1/1/2021</b>	Policy Version Change Policy Section Change: Definitions section updated Policy List Changes: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Codes Subject to the PC/TC Concept Without RVU Splits, Gap Fill Codes, Stand-alone Professional Component Only Codes (PC/TC Indicator 2), Stand-alone Technical Component Only Codes (PC/TC Indicator 3), Stand-alone Global Test Only Codes (PC/TC Indicator 4),

	Professional Component Codes (PC/TC Indicator 6 or 8), Laboratory Codes with a PC/TC Indicator 3 or 9, ASCFS Addendum BB PC/TC Indicator 1 Codes State Exceptions Section: Added exception for Kentucky History Section: Entries prior to 1/1/2019 archived
<b>9/27/2020</b>	Policy Version Change Policy List Change: Laboratory Codes with a PC/TC Indicator 3 or 9
<b>8/30/2020</b>	Policy Version Change State exceptions section: Updated exception for Ohio
<b>6/28/2020</b>	Policy Version Change Policy List Change: Laboratory Codes with a PC/TC Indicator 3 or 9
<b>5/12/2020</b>	Policy Version Change Policy List Change: Laboratory Codes with a PC/TC Indicator 3 or 9
<b>5/1/2020</b>	Annual Anniversary Date and Version Change Removed modifier descriptions and tables
<b>3/12/2020</b>	State exceptions section: Removed reference to Louisiana Policy version updated from 2020R0012B to 2020R0012C Removed all files and references to Louisiana contained in the body of the policy, information has been moved to the "Louisiana Only" policy
<b>2/16/2020</b>	State Exceptions Section: Updated exception for Kansas
<b>1/1/2020</b>	Policy Version Change Policy List Changes: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Codes Subject to the PC/TC Concept Without RVU Splits, Gap Fill Codes, Stand-alone Technical Component Only Codes (PC/TC Indicator 3), Laboratory Codes with a PC/TC Indicator 3 or 9, ASCFS Addendum BB PC/TC Indicator 1 Codes Added Q&A #5 State Exceptions Section: Added exception for Kansas History/Updates section: Entries prior to 1/1/2018 archived
<b>11/17/2019</b>	State Exceptions Section: Updated exception for Washington
<b>10/22/2019</b>	State Exceptions Section: Updated exception for Mississippi (MSCAN)
<b>9/29/2019</b>	Policy Version Change Policy Change: Overview; UnitedHealthcare Professional/Technical Splits; Reimbursement for Professional/Technical Component Based on POS; Duplicate or Repeat Services for Professional/Technical Eligible Codes updated Added Q&A #4
<b>7/30/2019</b>	Policy Version Change Policy List Change: Gap Fill Codes
<b>6/25/2019</b>	State Exceptions Section: Updated exception for Mississippi (MSCAN and MSCHIP)
<b>1/6/2006</b>	Policy Implemented by UnitedHealthcare Community & State