Clover

Clover Health Professional/Technical Component Reimbursement Policy

Policy # RP-071

Policy Title	Professional/Technical Component Reimbursement Policy
Policy Department	Payment Strategy Operations
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Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgement in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

This policy outlines Clover Health's reimbursement of professional and technical services submitted by both contracted and non-contracted providers for Clover's Medicare Advantage plans.

Definitions:

- Global Service
  - A Global Service includes both a Professional Component and a Technical Component. Global Service indicates that the same provider provided the supervision, interpretation and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. The Global Service is identified by reporting the appropriate professional/technical split eligible procedure code with no modifier attached or by reporting a standalone code for global test only services.
- Professional Component (PC)
  - Represents the supervision and. interpretation of a procedure provided by the physician or other healthcare professional.

- Technical Component (TC)
  - Represents the cost of the equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code.
- Stand-Alone Code
  - A Stand-alone Code describes a specific component of a selected diagnostic test. There is a specific code that describes the Professional Component only of the diagnostic test, another associated code that describes the Technical Component only, and another associated code that describes the global test only.

Policy:

The CMS Medicare Claims Processing Manual, Pub. 100-4, Chapter 12 states, "For diagnostic procedure codes and other codes describing services with both professional and technical components, relative values are provided for the global service, the professional component, and the technical component. The CMS makes the determination of which HCPCS codes fall into this category." It further specifies that the global service for professional (PC) and technical (TC) components are submitted by the physician when a technician furnishes the TC portion of the service under direct physician supervision and that physician also furnishes the PC portion, including the interpretation and report. In summary, if the global service is already submitted for the same date of service and there is another line/claim with modifier 26 or TC, then both history as well as current line/claim will be reviewed to check the appropriate use of modifier.

Claims for CPT/HCPCS codes that are billed with a TC and/or PC modifier in addition to the global procedure by the same provider, will be denied.

PC/TC Indicator 0 - Physician Only Services:

Physician service codes that describe physician only services. The use of modifier 26 or TC is not appropriate for these codes.

PC/TC Indicator 1 - Diagnostic Tests:

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.

PC/TC Indicator 2 - Professional component only codes:

This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.

PC/TC Indicator 3 - Technical component only codes:

This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.

PC/TC Indicator 4 = Global test only codes:

This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

PC/TC Indicator 5 = Incident to Codes:

This indicator identifies codes that describe services covered incident to a physician's service when they are provided by personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

PC/TC Indicator 6 = Laboratory physician interpretation codes:

This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.

PC/TC Indicator 7 = Physical therapy service:

Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.

PC/TC Indicator 8 = Physician interpretation codes:

This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatients. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is made

to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

PC/TC Indicator 9 = Concept of a professional/technical component does not apply

Modifier TC is appended to CPT(R) or Healthcare Common Procedure Coding System (HCPCS) procedure codes based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File and guidelines from generally accepted third-party industry sources like the American Medical Association (AMA). Only codes that are a combination of a physician component and a technical component should be submitted with either a modifier 26 (professional component) or modifier TC (technical component) appended. Modifier TC is not appropriate with procedures that represent 100 percent technical services.

Claim Codes (if applicable)	● Modifier 26 ○ Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. ● Modifier TC ○ Technical component; 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

References
Physician RVU Files
Medicare Claims Processing Manual Chapter 12