JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.040
		Effective Date	11/11/2024
		Approval Date	08/14/2024
	Subject **Professional and Technical Components**	*Supersedes Date*	N/A
		Original Date	N/A
		Page	1 of 9

This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Global Services, Modifier 26, PC/TC, ProTech

Table of Contents		Page Number

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHC policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHC reimbursement policies are developed based on nationally accepted industry standards, coding

principles, and follows CMS guidelines and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHC may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHC reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

This policy provides basic reimbursement guidance on the appropriate reporting of Modifier 26, the Professional component (PC) and Modifier TC for the Technical component (TC) of the service, when rendered within the provider's scope of practice, under state and federal law, and adheres to correct coding guidelines. This JHHP reimbursement policy applies to items and services reported using the CMS-1500 or the UB-04, or their electronic equivalents.

III. POLICY STATEMENT

JHHP will utilize editing software to identify certain CPT/HCPCS codes, and determine if the code can be reported as a Technical or a Professional component of the service rendered. JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. JHHP will reimburse providers who perform the professional component and/or technical component of a global procedure or service, when they appropriately append with Modifier 26 or TC, to the covered procedure, in alignment with CMS guidance
   - Other policies and coverage determination guidelines may apply.
2. When applicable, JHHP will cross-reference both professional and facility claims for our members, when billed for the same date of service.
3. In accordance with CMS, JHHP will implement reductions to the allowed amount of the technical component (TC) of radiological services when appended with modifier CT, FX or FY.
4. The name and NPI number of the referring/ordering physician or qualified non-physician practitioner must be reported on the claim form.
   - The physician interpreting the test must be identified on the claim form with his/her sequence number in Box 24K of the CMS-1500.
5. Physicians (or other qualified healthcare providers) who perform services in a facility setting, will not be reimbursed for the global procedure or the technical component. Only the facility can be reimbursed for the technical component of the procedure or service that was performed.

6. JHHP will reimburse the interpreting physician for only the professional component, when services are provided in a facility setting.
7. Only the facility is reimbursed for the technical component of the service. This guidance is applicable to services that are subject to the PC/TC concept, or have both a Professional and a Technical component according to the CMS PC/TC indicators.
8. CPT codes subject to the professional and technical component rules and modifiers, are maintained in the Medicare Physician Fee Schedule Database (MPFSDB).
9. The ICD-10 CM Coding Guidelines for Outpatient Services (hospital-based and physician office) instruct physicians to report diagnoses based on test results.
10. Appropriate documentation must support all codes billed. Claims for certain services may be pended for further review.
11. The interpretation of a diagnostic procedure includes a written report.
    i. Providers/suppliers shall not report radiologic supervision and interpretation codes, radiologic guidance codes, or other radiology codes where the radiologic procedure is integral to another procedure being performed at the same patient encounter.
    ii. JHHP may conduct medical record documentation reviews on a randomly selected sample of practitioners or on providers who render services outside their regular scope of practice or assigned specialty.
    iii. Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

V. MODIFIER 26 GUIDANCE

1. Append modifier 26 to the claim line when the following applies:
    - When the PC is outlined as a physician's service, which may include technician supervision, interpretation of results and a written report.
    - To report the physician's interpretation of a test, but does not perform the test.
    - Procedures that have a "1" in the PC/TC field on the MPFSDB.
    - This modifier must be reported in the first modifier field.
    - Modifier 26 must be reported in the first modifier field.

VI. MODIFIER TC GUIDANCE

1. Use modifier TC:
    - When the physician performs the test but does not do the interpretation.
    - For procedures that have a "1" in the professional component (PC)TC field on the MPFSDB.
2. Modifier TC must be reported in the first modifier field.
3. Portable x-ray suppliers should bill only for the technical component by appending Modifier TC.

VII. INAPPROPRIATE BILLING OF SERVICES

1. Do not add modifier TC when:
    - Professional component only procedure codes identified on the MPFSDB by a "2" in the PC/TC column.
    - Global test only procedure codes identified on the MPFSDB by a "4" in the PC/TC column.
    - Technical component only procedure codes identified on the MPFSDB by a "3" in the PC/TC column.
    - CPT codes 93224-93229, 93268, 93270, 93271, or 93272 are reported.
    - TC procedures are institutional and cannot be billed separately by the physician when the patient is:
        - In a covered Part A stay in a skilled nursing facility (SNF) location;
        - Inpatient; or

- Outpatient

2. Do not append modifier 26:
   - With evaluation and management (E/M), anesthesia codes or with CPT 93224-93229, 93268, 93270, 93271, or 93272;
   - Procedure or service descriptors that indicate professional component only;
   - Global test only codes (ex: CPT 93000);
   - Professional component only procedure codes identified on the MPFSDB by a "2" in the PC/TC column (ex: CPT 93010);
   - Re-read results of an interpretation provided by another physician

VIII. EXCEPTIONS and EXCLUSIONS

A. **Maryland Waiver Hospitals-** In accordance with §1814 (b)(3) of the Act, services provided by hospitals in Maryland are subject to the billing and reimbursement guidance of the Health Services Cost Review Commission (HSCRC). Claims from hospitals that are under the jurisdiction of the HSCRC will be processed and reimbursed under the terms of the HSCRC waiver.

B. **PPMCO:** JHHP will process and reimburse claims in accordance with Code of Maryland Regulations (COMAR) and the Maryland Department of Health (MDH) guidance. Please consult the authoritative guidance found on these entities' websites, to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
   1. In alignment with MDH, JHHP recognizes modifier -TC only on certain radiology procedure codes (70000-79999); providers may not use modifier –TC for procedures outside of radiology.
   2. MDH recognizes modifier -26 for both radiology and medicine services.
   3. JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   4. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.

C. **USFHP:** JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage.

IX. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition

Computerized Axial Tomography (CT/CAT)	A CT/Computerized Axial Tomography (CAT) scan is interchangeably referred to as either a CT or CAT scan. This diagnostic test uses x-ray technology to create three-dimensional, computerized images of internal organs. However, unlike a traditional x-ray, CT/CAT scans are able to distinguish between obscured and overlapping parts of the body. CAT scans are also capable of producing images of several different internal components, including soft tissue, blood vessels and bones.
Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare Professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Magnetic Resonance Angiography (MRA)	MRA techniques generate contrast between flowing blood and surrounding tissue, and provide anatomic images that can be provided in a format similar to that of conventional x-ray angiography, and can also provide physiologic information.
Magnetic Resonance Imaging (MRI)	MRI uses radio frequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. These tomographic images represent the tissue being analyzed and the environment surrounding it. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to Computerized Tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.
Medically Unlikely Edit (MUE)	An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/ supplier for the same member on the same date of service

Radiology	Radiology is the science that deals with the use of radiant energy, such as X-rays, radium, and radioactive isotopes, in the diagnosis and treatment of disease. Radiology is an important diagnostic tool useful for the evaluation of a variety of conditions.

CPT Codes

CPT Codes	Definition
70000-79999	Please refer to the AMA CPT book for all radiology procedures, including diagnostic imaging, ultrasound, radiation oncology, and nuclear medicine. There are many code categories. Each category may have specific guidelines, or the codes may include specific details.
99202-99499	Please refer to the AMA CPT book for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499). There are many code categories. Each category may have specific guidelines, or the codes may include specific details.

Professional Component (PC)/Technical Component (TC) Indicator

Indicator	Definition
0	Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into Professional and Technical components. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. • Modifiers 26 & TC **cannot** be used with these codes.
1	Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a Professional and Technical component. • Modifiers 26 and TC **can** be used with these codes.

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. The total RVUs for Professional component only codes include values for physician work, practice expense, and malpractice expense. • Modifiers 26 and TC **cannot** be used with these codes.
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. • Modifiers 26 and TC **cannot** be used with these codes.
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. 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. • Modifiers 26 and TC **cannot** be used with these codes.
5	Incident to Codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary 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.

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. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. • Modifier TC **cannot** be used with these codes.
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.
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 inpatient. This applies only to code 85060. **No TC** billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.
9	Concept of a Professional/Technical component does not apply.

Modifiers

Modifier	Definition
CT	Modifier CT must be reported for computed tomography (CT) services that are furnished on non-NEMA Standard XR-29-2013-compliant CT equipment. The allowed amount for these services will be reduced by15%.
FX	Modifier FX indicates that the x-ray was performed using film. The allowed amount for services provided prior will be reduced by 10%.
FY	Modifier FY should be appended to a code when the x-ray was taken using computed radiography technology/ cassette-based imaging. The allowed amount for services provided will be reduced by 10%.
TC	Modifier TC is used when only the Technical component (TC) of a procedure is being billed when certain services combine both the Professional and Technical portions in one procedure code.

26	Professional component. Used to report the physician's interpretation of a test.

X. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Medicaid Professional Services Provider Manual
- Medicare Claims Processing Manual Ch. 13- Radiology Services and Other Diagnostic
- Medicare Benefit Policy Manual CH. 15– Covered Medical and Other Health Services
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 4- Part B Hospital (Including Inpatient Hospital Part B and OPPS)
- Medicare Claims Processing Manual CH. 23- Fee Schedule Administration and Coding Requirements
- Medicare National Coverage Determinations Manual
- MLN MM9250- Payment Reduction for Computed Tomography (CT) Diagnostic Imaging
- Novitas JL- Modifier 26 Fact Sheet
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual
- TRICARE Manuals- Payment For Professional/Technical Components Of Diagnostic Services

XI. REVISION HISTORY

Date	Review or Revision	Reason for Modification	Approved By
08/14/2024	New Policy	N/A	Reimbursement Authorizations and Coding Committee (RAC)