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 uses 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 may 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 (QHP), including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals (QHP).

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.

NPFS PC/TC Indicator	Description
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 (QHP) 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.

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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.

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 (QHP) 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 (QHP) 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:

Physician Fee Schedule 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

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Community Plan will reimburse the interpreting physician or other qualified Health Care Professional (QHP) 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 (QHP) 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 (QHP) 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 Professional (QHP) 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 Professional (QHP) 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

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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 Professional (QHP) 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.

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

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 (QHP) 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	

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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 (QHP). When services are eligible for reimbursement under this policy, only one physician or other qualified Health Care Professional (QHP) 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 (QHP) 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 (QHP) 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 (QHP), 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 Professional (QHP) 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 (QHP), and a different physician or other qualified Health Care Professional (QHP) 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.

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- 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 of a radiology service (whether reported globally or with modifier 26) assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service. This is applicable only when the E/M and radiology services are performed by the Same Individual Physician or Other qualified Health Care Professional (QHP) 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 rendered on the same day. To be considered for additional reimbursement, a provider must submit a written radiology interpretation report for a radiology service appended with modifier 26 or reported globally. (See the Radiological Codes Requiring Attached Report list.)

American College of Radiology (ACR) guidelines suggest that physicians and other qualified Health Care Professional (QHP) 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

For additional information, refer to the Questions and Answers section, Q&A #6 & #7.

State Exceptions	
All Medicaid Lines of Business	Codes 90471 and 90472 are allowed in a facility place of service.
Florida	Per state regulations: • FL has a set of codes, when billed with a modifier 26, by a Pathologist, in place of service 21, 22, or 23, are excluded from the PC/TC editing. • CPT codes 92587 and 92588 are reimbursable in a facility place of service (POS 19, 21, 22, 23, 24, 26, 34, 51, 52, 55, 56, 57 or 61).

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Hawaii	Per state regulations, a written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Idaho	Per state regulations, a written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Indiana	Per state regulations, A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Kansas	Per State Regulations: • CPT code 59025 is reimbursable in POS 22. • CPT code 92587 is reimbursable in all facility place of services, except POS 21 (POS 19, 22, 23, 24, 26, 34, 51, 52, 55, 56, 57 or 61). • CPT code 92588 is reimbursable in all facility place of services (POS 19, 21, 22, 23, 24, 26, 34, 51, 52, 55, 56, 57 or 61). However, Place of service 21 is not reimbursable for newborns during the date span of the delivery hospital stay. • CPT code 96160 and 96161 are reimbursable in facility POS 19, 22, 23 and 57. • A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service
Kentucky	Per state regulations • CPT codes 88300-88399 and 89250-89356 are excluded from PC/TC editing. • CPT codes 80305, 80306 and 80307 are excluded from PC/TC in POS 55 and 57. • A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Maryland	Per state regulations • CPT codes 92587 & 92588 are reimbursable in a facility place of service (POS 19, 21, 22, 23, 24, 26, 34, 51, 52,55, 56, 57 or 61). • A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Mississippi	Per state regulations: • MSCAN and MSCHIP allow reimbursement for codes 96160 and 96161 when submitted with Modifier EP in a facility place of service • MSCAN allows reimbursement for 94640 and 85060 in all POS billed by professional and facility.
New Jersey	Per state regulations, NJ allows the 96156 when billed with a modifier 26, by Behavioral providers in place of service 11, 02, 12, 10, 22, 50, 21 or 23 and excluded from the PC/TC editing.
New Mexico	Per NM State regulations, • Claims with POS 57 are reimbursable. • A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.

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New York	Per NY state regulations: • CPT codes, 92587, 92588 are reimbursable in a facility place of service (POS 19, 21, 22, 23, 24, 26, 34, 51, 52, 55, 56, 57 or 61).
North Carolina	Per state regulations CPT code 96161 is reimbursable in a facility place of service 19, 21, 22, 23, 26, 34, 51, 52,55,56, 57 and 61.
Ohio	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
Pennsylvania	PA considers CPT codes 92587 & 92588 reimbursable in a facility place of service (POS 22).
Tennessee	Per state regulations, a written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Rhode Island	Per state regulations, a written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Texas	Per state regulations: CPT code 92066 is excluded from this policy.
Virginia	VA considers CPT codes, 92587, 92588 reimbursable in a facility place of service (POS 23, 34, 51, 52, 55, 56, 57 or 61).
Washington	Per state regulations • H0003 is allowed in a facility place of service • CPT codes 92537, 92650, 92651, 92652, and 92653 are allowed in place of service 21. • CPT codes 96127, 96160, 96161 are excluded from this policy. • A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Washington DC	Per state regulations, a written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.
Wisconsin	Per state regulations, • Considers place of service 19 as a non-facility and allows code H0049 • A written radiology interpretation report is not required for PC/TC Indicator 1 radiology codes when billed with modifier 26 and an E/M service.

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified Health Care Professional (QHP) 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.
Duplicate or Repeat Services	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.

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Gap Fill Code	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.
Global Service	A Global Service includes both a Professional Component and a Technical Component. When a physician or other qualified Health Care Professional (QHP) 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 (QHP) 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.
Independent Laboratory	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).
Non-Reference Laboratory	A physician or a Pathologist reporting laboratory procedures performed in their office
Pathologist	A Pathologist is a physician who specializes in diagnosing diseases by examining tissue, blood, and body fluids using advanced laboratory techniques.
Professional Component	The Professional Component represents the physician or other qualified Health Care Professional (QHP) work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other qualified Health Care Professional (QHP) 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.
Reference Laboratory	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.
Relative Value Unit (RVU)	The assigned unit value of a particular CPT or HCPCS code. The associated RVU is from CMS NPFS Non-Facility Total value.
Resource-Based Relative Value Scale (RBRVS)	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.
Same Individual Physician or Other Qualified Health Care Professional (QHP)	The same individual rendering health care services reporting the same Federal Tax dentification number.
Specimen	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.
Stand-alone Code	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

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	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.
Technical Component	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	**Q:** If a physician or other qualified Health Care Professional (QHP) 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? **A:** 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 (QHP) will not be impacted by UnitedHealthcare Community Plan's quarterly updates to the percentage calculation methodology for Professional Component and Technical Component reimbursement.
3	**Q:** When does UnitedHealthcare Community Plan give consideration for repeat procedures by the same individual physician, another physician or other qualified Health Care Professional (QHP) when reported with modifiers 76 or 77? **A:** 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 Professional (QHP) 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. 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.
4	**Q:** 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? **A:** 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.
5	**Q:** 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?

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	A: 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 (QHP).
6	**Q:** If the Same Individual Physician or Other qualified Health Care Professional (QHP) reports modifier 59, XE, XP, XS or XU in addition to modifier 26 on a PC/TC Indicator 1 code, e.g., 70110-26-59, to indicate that it is a separate and distinct service from their E/M service performed on the same date, will UnitedHealthcare consider separate reimbursement for the radiology interpretation? **A:** As outlined in the "Professional Component with an Evaluation and Management Service" section of this policy, UnitedHealthcare requires submission of a distinctly identifiable signed written radiological report separate from the E/M service performed, even when modifier 59, XE, XP, XS or XU is reported, before separate reimbursement for the radiology interpretation will be considered.
7	**Q:** If the Same Individual Physician or Other qualified Health Care Professional (QHP) reports an E/M code with modifier 25 on the same day as their radiology interpretation appended with modifier 26, will the requirement of submitting supporting documentation for the radiology interpretation be bypassed? **A:** No, per CPT guidelines, modifier 25 is reported to identify a separate and distinct E/M service. In this scenario, it is the radiology interpretation that requires documentation for separate reimbursement.

Attachments

CS-Professional-Technical-Component-Codes-(PCTC-Indicator-1-Diagnostic-Tests)	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.
Codes Subject to the PC/TC Concept Without RVU Splits	A list of PC/TC Indicator 1 Diagnostic Test codes subject to the CMS PC/TC component concept without RVUs for one or more components. These codes are allowed at 100% for both the Professional Component and the Technical Component.
CS-Gap-Fill-Codes	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.
CS-Laboratory-Codes-with-a-PCTC-Indicator-3-or-9	A list of codes that have been assigned a PC/TC Indicator of 3 or 9. ***PC/TC Indicator 3:*** *T*echnical Component Only Code ***PC/TC Indicator 9:*** The concept of a PC/TC component does not apply These services are not reimbursable when submitted with the Professional Component (modifier 26).
CS-ASCFS-Addendum-BB-PCTC-Indicator-1-Codes	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.
ASCFS Addendum BB PC/TC Indicator 3 Codes	A list of codes with a PC/TC Indicator 3 that when reported in a CMS POS 24 (ambulatory surgical center) will be denied.

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Radiological Codes Requiring Attached Report	A list of PC/TC Indicator 1 radiology codes reported globally or appended with modifier 26 requiring the submission of a written interpretation radiology report when billed with an E/M service.
CS-FL-Laboratory-Codes-Excluded-from-PCTC-Editing	A list of codes when billed with a modifier 26, by a Pathologist, in place of service 21, 22, or 23, that are excluded from the PC/TC editing.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American College of Radiology – ACR Practice Guideline for Communication of Diagnostic Imaging Findings
Practice Parameters and Technical Standards | American College of Radiology (acr.org)

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

10/18/2026	Policy Version Change Attachment Section: Policy List Updates: ASCFS Addendum BB PC/TC Indicator 3 Codes History Section: Entries prior to 10/18/2024 archived
9/22/2026	Policy Version Change State Exceptions Section: Idaho Updated History Section: Entries prior to 9/22/2024 archived
9/20/2026	Policy Version Change State Exceptions Section: Idaho Added Attachment Section: Policy List Updates: Laboratory Codes with a PC/TC Indicator 3 or 9 History Section: Entries prior to 9/20/2024 archived
7/19/2026	Policy Version Change Attachment Section: Policy List Updates: ASCFS Addendum BB PC/TC Indicator 3 Codes History Section: Entries prior to 7/19/2024 archived
6/7/2026	Policy Version Change State Exceptions Section: North Carolina updated
4/26/2026	Policy Version Change Attachment Section: Policy List Updates: ASCFS Addendum BB PC/TC Indicator 1 Codes list and ASCFS Addendum BB PC/TC Indicator 3 Codes list updated History Section: Entries prior to 4/26/2024 archived
4/1/2026	Policy Version Change Policy Section Update: Professional Component with an Evaluation and Management Service and Attachments (Radiological Codes Requiring Attached Report) Verbiage update. History Section: Entries prior to 4/1/2024 archived
3/29/2026	Policy Version Change Attachment Section: Policy List Updates: ASCFS Addendum BB PC/TC Indicator 1 Codes updated History Section: Entries prior to 3/29/2024 archived

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2/15/2026	Policy Version Change Attachment Section: Policy List Updates: ASCFS Addendum BB PC/TC Indicator 1 Codes updated, ASCFS Addendum BB PC/TC Indicator 3 Codes Added/updated History Section: Entries prior to 2/15/2025 archived
1/12/2026	Policy Version Change Policy List Updates: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Gap Fill Codes and Codes Subject to the PC/TC Concept Without RVU Splits updated
1/1/2026	Policy Version Change Policy List Updates: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Gap Fill Codes, Laboratory Codes with a PC/TC Indicator 3 or 9, Radiological Codes Requiring Attached Report, ASCFS Addendum BB PC/TC Indicator 1 Codes, Codes Subject to the PC/TC Concept Without RVU Splits, and ASCFS Addendum BB PC/TC Indicator 3 Codes updated
12/14/2025	Policy Version Change State Exceptions Section: Tennessee updated History Section: Entries prior to 12/14/2023 archived
11/23/2025	Policy Version Change Policy List Update: ASCFS Addendum BB PC/TC Indicator 3 Codes updated
11/09/2025	Policy Version Change Policy List Update: Florida Laboratory Codes Excluded from (PC/TC) Editing updated
11/02/2025	Policy Version Change State Exceptions Section: Hawaii, Indiana, Rhode Island and Washington DC Added and Kansas, Kentucky, Maryland, New Mexico, Washington, and Wisconsin updated
7/13/2025	Policy Version Change State Exceptions Section: California Removed Policy List Update: ASCFS Addendum BB PC/TC Indicator 3 Codes updated
6/29/2025	Policy Version Change Policy List Update: Laboratory Codes with a PC/TC Indicator 3 or 9 updated
5/11/2025	Policy Version Change State Exceptions Section: New Mexico added History Section: Entries prior to 5/11/2023 archived
3/30/2025	Policy Version Change Policy List Update: Laboratory Codes with a PC/TC Indicator 3 or 9 updated History Section: Entries prior to 3/30/2023 archived
02/16/2025	Policy Version Change Policy List Update: Florida Laboratory Codes Excluded from (PC/TC) Editing updated
1/26/2025	Policy Version Change Policy List Update: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Codes Subject to the PC/TC Concept Without RVU Splits, and Gap Fill Codes
1/12/2025	Policy Version Change Policy List Update: ASCFS Addendum BB PC/TC Indicator 1 Codes History Section: Entries prior to 1/12/2023 archived
1/1/2025	Policy Version Change Policy List Updates: Professional/Technical Component Codes (PC/TC Indicator 1 Diagnostic Tests), Gap Fill Codes, Laboratory Codes with a PC/TC Indicator 3 or 9, and Radiological Codes Requiring Attached Report

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11/21/2024	Policy Version Change State Exceptions Section: Florida updated
1/6/2006	Policy Implemented by UnitedHealthcare Community & State

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