Technical vs. Professional Component

Properly reporting the technical and professional components for procedures is a difficult issue facing coding professionals today. As experienced coders know, CPT coding guidelines do not specifically address billing for the technical component of a procedure or service.

CPT does provide a coding convention for separately reporting the professional component (or physician component) of a procedure or service. In this article, we will take a look at CPT’s coding convention for reporting the professional component and additionally discuss reporting the technical component of a procedure or service.
Procedures included in CPT may be performed by physicians and other healthcare practitioners. Certain procedures are a combination of a physician professional component and a technical component. For procedures with both a technical and professional component, modifier -26 may be used to indicate that the professional component portion of the procedure is being reported separately.

In general, if a procedure is comprised of both a technical and professional component, and is performed on facility owned equipment, it may be necessary for the physician to indicate that he/she is reporting only the professional component, by appending modifier -26 to the procedure code(s) reported. This is because the facility may be reporting the “technical component” of the procedure.

Unmodified CPT codes are intended to describe both the technical and professional components of a service. The professional and technical components together are referred to as the “global service.” If the technical and professional components of the service are performed by the same provider, then it is not appropriate to report the components of the service separately.

Technical Component

Since CPT codes are intended to represent physician and other healthcare practitioner services, CPT does not contain a coding convention to designate the technical component for a procedure or service. However, many third-party payors have established modifiers and/or specific reporting policies regarding the reporting of the technical component.

For example, Medicare established the -TC modifier for reporting the technical component. Based on information found on page 86 of the 1999 edition of Medicare RBRVS: The Physicians’ Guide, published by the American Medical Association, HCFA addresses professional versus technical components of services as follows:

“Professional and technical component modifiers were established for some services to distinguish the portion of a service furnished by a physician. The professional component includes the physician work and associated overhead and professional liability insurance (PLI) costs involved in three types of services:

- diagnostic tests that involve a physician's interpretation, such as cardiac stress tests and electroencephalograms;
- diagnostic and therapeutic radiology services; and
- physician pathology services.

The technical component of a service includes the cost of equipment, supplies, technician salaries, etc. The global charge refers to both components when billed together. For services furnished to hospital outpatients or inpatients, the physician may bill only for the professional component, because the statute requires that payment for nonphysician services provided to hospital patients be paid only to the hospital. This requirement applies even if the service for a hospital patient is performed in a physician’s office.”

The -TC modifier is HCFA’s coding convention for reporting the technical component. Other insurance companies may also require the use of the -TC modifier, or they may have developed their own method for reporting the technical component.

Professional versus Technical Component for Clinical Laboratory Services (CPT codes 80049-87999)

The use of the -26 modifier is required for CPT codes 80049-87999 in those instances when the physician is only billing for the professional component of the laboratory test (i.e., medical direction, supervision or interpretation). This method of reporting is appropriate when the technical and professional components are reported separately.

There are a number of ways to report the professional services of the physician in the hospital clinical laboratory. The physician may bill the patient (or patients insurer) or the hospital. Since the hospital’s Medicare payment rate includes payment for certain physician services, Medicare rules require the physician to seek payment from the hospital for medical direction and supervision of clinical laboratory tests. Billing using the -26 modifier is allowed for interpretation of specified tests.

For non-Medicare patients, pathologists and hospitals frequently negotiate different billing arrangements for professional services. As stated in the College of American Pathologists Professional Relations Manual (page 158, under the section: Pathologist
Professional Component Billing for Clinical Laboratory Services:

“Professional component billing is one valid method of billing for the professional services of pathologists in the clinical laboratory. In many communities, the standard practice is for the pathologist to direct bill patients for the professional component of clinical laboratory services. When the pathologist bills a professional component to a non-Medicare patient, no payment is made by the hospital to the pathologist for this service. The hospital’s bill for the technical component covers hospital costs for laboratory equipment, supplies and non-physician personnel – it does not include the professional services of the pathologist.”

In closing, when reporting the technical component of a procedure or service, it is important to familiarize yourself with the various reporting requirements of individual insurance companies in your area. These reporting and reimbursement policies may vary from one insurance company to another.

The *Medicare RBRVS: The Physicians’ Guide,* can be ordered by contacting the American Medical Association’s Customer Service department at 800 621-8335.

For information on the CAP manual, contact the College of American Pathologists at 202 371-6617.

References:


In the coming months

- -59 vs. -51
- Distal Flow Velocity Ultrasound
- Generation of Automated Data
- Biofeedback
- Coding Consultations

*Assistant*

**Editorial Staff**

Celeste Kirschner  Dan Reyes
Executive Editor  Managing Editor

**Contributing Staff**

Caryn Anderson, Stephanie Davis, Catherine Duffy, DeHandro Hayden, Jennifer Kopacz, Grace Kotowicz, Marie Mindeman, Karen O’Hara, Joan Zacharias

**Editorial Assistant**

Rejina Young

**Subscription Prices**

1 year (12 issues)
AMA Members $99  Nonmembers $139
2 years (24 issues)
AMA Members $179  Nonmembers $249

**Back Issues**

AMA Member $14.95  Nonmembers $19.95

**Phone orders:** Call 800 621-8335 (Fax 312 464-5600).
You may use your Mastercard, VISA, American Express or Optima Please have the following information ready: Cardholder’s name; a count number; expiration date; member number. To receive the member price, please provide the member’s number.

Send new address information to:

*CPT Assistant*

Subscription Department
515 North State Street
Chicago, Illinois 60610
AMA Web site address: http://www.ama-assn.org

Notification of change of address must be made at least six weeks in advance. Include your old and new address, a mailing label from your most recent issue of *CPT Assistant* and a telephone number.

The *CPT Assistant* is designed to provide accurate, up-to-date coding information. We continue to make every reasonable effort to ensure the accuracy of the material presented. However, this newsletter does not replace the *CPT Book,* it serves only as a guide.

©1999, American Medical Association. All rights reserved. No part of this publication may be reproduced in any form without prior written permission of the publisher. *CPT™* is a trademark of the American Medical Association.