



Reimbursement Policy Commercial

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Annual Review Date04/29/2024

Reimbursement Policy NumberM26

Modifier 26 Professional Component

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Related Coverage Resources

[Modifier TC- Technical Component](#)

INSTRUCTIONS FOR USE

Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy. Proprietary information of Cigna.
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Overview

This policy applies to the professional component of the global fee for the service rendered for Cigna Commercial and Individual Plans.

This policy applies to claims billed on a Center for Medicare and Medicaid Services (CMS) 1500 or UB04 claim form and all electronic equivalents.

Reimbursement Policy

Cigna provides separate reimbursement for the professional component of the global fee at the fee schedule or other allowed amount when modifier 26 is billed consistent with the Professional Component/Technical Component (PC/TC) indicators in the Centers for Medicare and Medicaid Services (CMS National Physician Fee Schedule Relative Value File (NPF SRVF)).

General Background

CMS defines a complete service (i.e., global fee) as one in which the physician provides the entire service, including the equipment, supplies, technical personnel, and the physician's professional services. There are services, however, that may be reported separately as the professional component (modifier 26) and/or the technical component (modifier TC).

Modifier 26 represents the professional component of the procedure. The professional component of the global fee is for the reading and interpretation of the diagnostic procedure/service.

The technical component of the global fee includes providing the equipment, supplies and technical personnel for a diagnostic procedure/service. Please refer to the Cigna Reimbursement Policy on Modifier TC for additional information regarding the technical component.

Many services in the surgery, radiology, pathology and medicine sections of the Current Procedural Terminology (CPT®) book consist of two components which together make up the complete service (the global fee).

- Professional Component (PC)-includes the physician's work in providing the services (e.g., reading x-ray films), interpreting diagnostic test(s) and preparing the written report. The physician must prepare a written report of the clinical findings which includes a comparison to previous studies (if appropriate). According to CMS, if no written report is made documenting the clinical findings, it would not be appropriate to use Modifier 26.
- Technical Component (TC)-includes providing the equipment, supplies, technicians and costs associated with the performance of the procedure (other than the professional services).

When a facility/institution/physician owns the equipment, purchases the supplies and employs a technician to perform the procedure as well as a physician to interpret the results, they are performing a complete service (i.e., global fee). In these cases, neither modifier 26 nor TC would be appended to the service code.

There are certain procedure code descriptors that represent only the professional component portion of a procedure. An example of a procedure code with only a professional component is:

- 93010-Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

Since the description of CPT® code 93010 indicates "interpretation and report only", this code represents the physician's professional component only. It would not be appropriate to append modifier 26 (or modifier TC) to this code.

Not all CPT/HCPCS codes are appropriate for use with Modifier 26. Cigna uses the CMS PC/TC indicators in the National Physician Fee Schedule Relative Value File (NPFSRVF) to determine

if a CPT/HCPCS code is eligible for a separate professional service component reimbursement. Codes incorrectly appended with modifier 26 which have an associated PC/TC indicator of 3 or 9 are typically not reimbursed. However, under some circumstances when Cigna may deem it appropriate to reimburse those claims, we consider the market value of those services to be no more than \$5.00 per service code.

Correct Use of Modifier 26

- Modifier 26 is appended when a physician provides the professional component only of the global fee and when the physician prepares a written interpretation and report.
- Modifier 26 should only be appended to codes which are listed in the CMS NPFSRVF as modifier 26 appropriate.

Incorrect use of Modifier 26

- Modifier 26 is not appended when a facility/institution/physician owns the equipment, purchases the supplies, employs the technologist to perform the tests and employs the physician to interpret the tests. These features represent the global fee.
- Modifier 26 is not appended when a procedure does not have a technical component. Example: CPT® code 76140-Consultation on X-ray examination made elsewhere, written report. Modifier 26 would not be appended since the description of the code indicates "written report" which is the professional component.
- Modifier 26 should not be appended to any code which is not listed in the CMS NPFSRVF as modifier 26 appropriate.

References

1. Current Procedural Terminology (CPT®) Professional Edition©2022 American Medical Association: Chicago, IL.
2. Health Care Procedure Coding Systems (HCPCS®) ©2022 Practice Management Information Corporation: Los Angeles, California
3. American Medical Association. Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage. Fifth Edition. ©2014.
4. CMS National Physician Fee Schedule Relative Value File (NPFSRVF). Accessed 04/12/2023.
5. Optum 360° Understanding Modifiers: Comprehensive instruction to effective modifier application (2022), West Valley City, UT ©2022

Policy History/Update

Date	Change/Update
08/17/2023	Policy put onto updated template.

Date	Change/Update
04/23/2023	Policy updated: refreshed references, added the Cigna lob that the policy applies to and clarified policy statement regarding CMS payment policies to CMS NPFSRVF.
08/02/2022	Effective date 07/01/2022 for policy statement for codes incorrectly appended with modifier 26 but determined to be reimbursable at market value per service code.
04/01/2022	Notification for policy statement for codes incorrectly appended with modifier 26 but determined to be reimbursable at market value per service code. Effective 07/01/2022.
09/27/2021	Notification for denial of Modifier 26 when inappropriately billed per the CMS National Physician Fee Schedule Relative Value File (NPFSRVF). Effective 10/27/2021. State mandates may delay effective date for regulated states.
06/04/2021	Denial for the inappropriate use of Modifier 26 placed on hold until further notice.
04/12/2021	Notification for denial of Modifier 26 when inappropriately billed per the CMS National Physician Fee Schedule Relative Value File (NPFSRVF). Effective 07/11/2021.
05/22/2018	Policy template updated.
11/10/2016	Policy template update. Changed "fee schedule/MRC" to "fee schedule or other allowed amount".
02/18/2014	Policy template updated
08/06/2009	Policy effective for former Great West Healthcare
06/23/2008	Policy revised: added reference to PC/TC indicators in the CMS Physician Fee Schedule
05/06/2009	Updated format. Policy notification for former Great West Healthcare
05/15/2007	Policy effective for CIGNA HealthCare

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