



HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule

<p>Number: Draft Professional and Technical Component Rule 207 V.03 2/6/14</p>	<p>Statutory reference: C.R.S. 25-37-106</p>
<p>Topic</p>	<p>Professional and Technical Component</p>
<p>Definition</p>	<p>This type of edit will identify incorrect billing of a procedure code that is either not eligible for the professional/technical split, or incorrectly identifies the professional or technical component.</p>
<p>Associated Current Procedural Terminology (CPT®)¹ and HCPCS modifiers</p>	<p>-26 Professional Component: 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.</p> <p>-90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.</p> <p>-TC Technical Component:² 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.</p> <p>Note: Professional providers in certain circumstances can bill for the technical components, refer to the Administrative guidance for more information.</p> <p>This rule is applicable for the specific situations identified for these modifiers. There may be appropriate situations where multiple modifiers apply, however they are not covered in this document.</p>
<p>Rationale</p>	<p>The following rationale was used to formulate the Professional and Technical Component rule:</p> <ul style="list-style-type: none"> • The CPT® coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.

¹ Current Procedural Terminology (CPT®), Fourth Edition. 2013. Copyright 2013. All rights reserved,

² This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare. Additionally as identified by the College of American Pathologists, the statement that "Technical component charges are institutional charges and not billed separately by physicians." is specific to Medicare as well as, there is no federal requirement for the TC (ie, histology slide preparation) to be performed in a Clinical Laboratory Improvement Amendments (CLIA) laboratory facility. Many TC services are, in fact, not performed in CLIA laboratories and therefore the term "institutional" is not an applicable term for the performance of the TC for anatomic pathology services.

	<ul style="list-style-type: none"> • The CPT® descriptor for modifier 26 and HCPCS modifier TC were selected. • The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual³ were selected. • Any CPT® codes that were exceptions to the CMS pricing policy were identified and if applicable included in the Professional and Technical Component Rule.
<p>Rule logic</p>	<p>Procedures subject to the Professional and Technical Component Rule are listed in the Medicare Physician Fee Schedule (MPFS) column labeled PCTC.⁴</p> <p>Professional component (26) and technical component (TC) modifier identification applies to procedure codes with an indicator of 1. Modifiers 26 and TC may be appended to describe the professional and technical components respectively when appropriate.</p> <p>Professional component only codes are identified with an indicator of 2, 6 or 8.</p> <ul style="list-style-type: none"> - For procedure codes with an indicator of 2 or 8 it is inappropriate to report modifier 26 or TC. - Procedure codes with an indicator of 6 should be reported with a modifier 26. It is inappropriate to report modifier TC. <p>Technical component (TC) only codes are identified with an indicator of 3. It is inappropriate and unnecessary to append a TC modifier.</p> <p>Professional component (26) and technical component (TC) modifier identification does not apply to procedure codes with an indicator of 0, 4, 5, 7 or 9. It is inappropriate and unnecessary to append a 26 or TC.</p> <p>Note:</p> <ul style="list-style-type: none"> - CPT® codes identified with PC/TC indicator 5 are not intended to be reported by the physician in the facility setting. These codes are typically not eligible for payment when reported with a facility place of service (POS 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61)⁵. - It is inappropriate to append a 26 modifier, or TC modifier to services included in the Global Service; these codes are identified with a PC/TC indicator of 4. - As identified in CPT® coding guidelines⁶, “The use of modifier 26, Professional component, is required for CPT codes 80048-89356 in those instances when the physician is only billing for the professional component of the laboratory tests (e.g., medical direction, supervision or interpretation).” <p>Payment of professional component for clinical laboratory services may be subject to the individual payer’s policy/contract.</p> <p>Clinical laboratory services are identified on the MPFS with a status X and a PCTC indicator of 9.</p>
<p>Administrative guidance</p>	<p>Coding and adjudication guidelines</p> <p>Because CPT® codes are intended to represent physician and other health care practitioner services, the CPT® nomenclature does not contain a coding convention to designate the technical component for a procedure or service. CPT® coding does provide modifier 26, professional component for separately reporting the professional (or physician) component of a procedure or service. This is because a hospital, other facility, or other qualified healthcare professional may be reporting the technical component of</p>

³ Chapter 12 – Physician/Nonphysician Practitioners. *Medicare Claims Processing Manual, Publication # 100-04.*

⁴ References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

⁵ Department for Health and Human Services Centers for Medicare and Medicaid Services MLN Matters 7631 Revised. Visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf> to access this document.

⁶ CPT Assistant article dated August 2005.

the procedure. The HCPCS Level II modifier TC is used to differentiate the professional versus technical components of the service provided.

Unmodified CPT® codes are intended to describe the global service (both the technical and professional components), professional component only or technical component only of a service. If the technical and professional components of the service are performed by the same provider, it is not appropriate or necessary to report the components of the service separately.

Professional versus Technical Component

Certain procedures described by the CPT® code set are a combination of a professional (physician) component and a technical component (i.e., diagnostic tests that involve a physician's interpretation, such as cardiac stress tests, electroencephalograms, or physician pathology services).

PCTC Indicators

The MPFS provides ten status indicators (0,1, 2, 3, 4, 5, 6, 7, 8 and 9) used to identify procedure codes for PC and TC.

The complete Medicare description of the TC modifier is located on page 10 of this rule; it indicates, "technical component charges are institutional charges..." This is not always the case and in fact Medicare acknowledged this in the Medicare Change Request 8013, Transmittal 2714 dated May 24, 2013. The Transmittal states that, "Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment... Payment may be made under the physician fee schedule for the TC of a physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients..."

Additionally, Medicare Learning Network Medicare Coverage of Imaging Services, ICN907164/June 2013 state: Medicare pays under the MPFS for the TC of imaging services furnished to Medicare beneficiaries who are not patients of any hospital, and who receive services in a physician's office, a freestanding imaging or radiation oncology center, ambulatory surgical center (ASC), or other setting that is not part of a hospital. When imaging services are furnished in a leased hospital radiology department to a beneficiary who is neither an inpatient nor an outpatient of any hospital, both the PC and the TC of the services are payable under the MPFS by the carrier or A/B MAC.

There may be other instances when it is appropriate for a physician or other qualified healthcare professional to submit a procedure code with the modifier TC appended. However, it is not appropriate to report more than one professional and one technical component charge, or one global charge for the same procedure when rendered to the same patient during the same encounter. Such charges would be considered duplicative. Some examples are noted below.

Example 1: Chest x-ray 1 view frontal performed by medical clinic technician, interpreted by a physician who is not a member of the medical clinic, place of service – office

Correct coding

Medical Clinic Technician – XXXXX TC

Physician – XXXXX 26

Incorrect coding

Medical Clinic Technician – XXXXX (no modifier)

Physician – XXXXX 26

	<p>Example 2: Intraoperative neurophysiological monitoring <u>in a free-standing ambulatory surgical center (ASC)</u> Assumes that the facility does not provide the technical component. An independent neurophysiological monitoring technician provides the equipment and supplies. A neurologist performs the professional component.</p> <p>Correct coding Technician – YYYYY TC Neurologist – YYYYY 26 Facility – No charge or payment for this service</p> <p>Incorrect coding Technician – YYYYY (no modifier) Neurologist – YYYYY 26 Facility – No charge or payment for this service</p> <p>Refer to the H- Place of Service rule for the Place of Service (POS) instructions for the interpretation of Professional Component (PC) and the Technical component (TC) of diagnostic tests.</p> <p>Note:</p> <ul style="list-style-type: none"> - As in the case with Medicare and Medicaid, under Colorado Revised Statutes (Chapter 41 §10-16-138, et seq.) the professional component of anatomic pathology services (CPT 88000 series) and subcellular/molecular pathology cannot be billed by a physician or other health care professional who performs no component of the service. In addition, the technical component of the Pap test (including, cytopathology services for cervical cancer screening codes 88141-8175) cannot be billed by a health care professional when such services are performed by an outside laboratory pursuant to state law. - Modifier 90 (outside laboratory) cannot be used by an ordering physician or other qualified health care professional to denote the performance of an anatomic pathology or subcellular/molecular pathology service unless the physician or other qualified health care professional has performed the professional component of the service.
<p>Specialty Society outreach</p>	<p>The AMA Federation Payment Policy Workgroup was consulted. The College of American Pathologists</p>
<p>Summary DATE</p>	<p>The task force will utilize the indicators listed in the PCTC column of the MPFS to identify the correct Professional Component, modifier 26, and Technical Component, modifier TC reporting as outlined in this rule. This information is included in the MPFS Relative Value file and can be accessed at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.</p> <p>Revised February 6, 2014</p>

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-

service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

Comments

The Task Force is working within the legislative framework of Colorado Revised Statutes Section 25-37-106 which outlines the sources to be used in the development of a standardized set of claims edits and payment rules. These parameters should be taken into consideration when providing comments. (Information on the Task Force and legislation can be found on at www.hb101332taskforce.org.)

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