Effective 3/20/2026

Lines Of Business: All Lines of Business

Payment Impacting Modifier: Technical (TC), Professional (26)

DISCLAIMER

This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any case. No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, whether electronic, mechanical, photocopying or otherwise, without express written permission from THP. When printed, this version becomes uncontrolled. For the most current information, refer to the following website: healthplan.org.

DEFINITIONS, ACRONYMS, and TERMS

Covered Service	Medically necessary services, as determined by the plan and described in the applicable benefit plan, for which a member is eligible for coverage
CPT	Current Procedural Terminology
Fee Schedule	The complete listing of rates for services that represents payment for each unit of service allowed based on applicable coded service identifier(s) for covered services
HCPCS	Healthcare Common Procedure Coding System

BACKGROUND

A modifier is two characters (letters or numbers) appended to a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. The modifier provides additional information about the product or service without changing the meaning of the code billed.

A pricing modifier is a modifier that causes a pricing change for the code billed.

POLICY

Modifier TC	Technical component of a service is performed
Modifier 26	Professional component of a service is performed

Modifier 26 is required for the professional component of a test when the physician or practitioner utilizes equipment owned by a hospital/facility or to report the physician or practitioner's interpretation of a test that is separate, distinct, and written.

The technical component includes the equipment, supplies, and costs related to the service. Modifier TC is required for the technical component of a service.

Modifier 26 or TC should **not** be used for:

- Professional component-only codes
    - i.e., 93010 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
- Technical component-only codes
    - i.e., 93005 Electrocardiogram; tracing only, without interpretation and report
- Global service codes
    - A global service includes both professional and technical components of a service when the same physician or practitioner performs both. It is identified by reporting the appropriate code without modifier 26 or TC.
        - i.e., 72040 Radiologic exam, spine, cervical; two (2) or three (3) views includes both the technical and professional component if performed by a single physician or practitioner

When billing for both the professional and technical component of a procedure when the technical component was purchased from an outside entity or facility, the professional and technical components must be billed on a single claim with separate lines. The modifier must be reported in the first modifier field.

Payment Impact

Modifier TC

Line of Business	Percentage (%) of Fee Schedule
Commercial	100%
Medicare	100%
Mountain Health Trust	100%
PEIA	100%
Self-Funded/ASO	100%

Payment Impact

Modifier 26

Line of Business	Percentage (%) of Fee Schedule
Commercial	100%
Medicare	100%
Mountain Health Trust	100%
PEIA	100%
Self-Funded/ASO	100%

As a reminder, The Health Plan (THP) applies claims edits to all services including those with modifiers.