Modifier TC

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Overview

Modifier TC is used when only the technical component (TC) of a procedure is being billed when certain services combine both the professional and technical portions in one procedure code.

Policy

Modifier TC is appended to billed codes to indicate that only the technical component of a service/procedure has been provided. It is generally billed by the entity that provided the testing equipment. Services with a value of "1" in the PC/TC Indicator field of the National Physician Fee Schedule may be billed with modifier TC. These are predominantly radiology services, but also include pathology, laboratory, and medicine services.

Modifier TC is generally not billed by hospitals and other facilities who bill using the UB-04 format. These facilities are presumed to be providing the technical component of a service. For the same reason, professional providers may not bill for the technical component of services provided to patients in a hospital or facility setting. However, Portable X-ray Suppliers may bill for a technical component of an x-ray performed in certain locations when also billing for portable x-ray transportation to the location.

It is not correct to append both modifier TC and 26 when an entire (global) service has been performed. In that case, no modifier should be used.

Modifier TC should not be appended to services that do not have a value of "1" in the PC/TC indicator field. This includes codes where the description indicates the services is technical, only (PC/TX = "3").

Examples:

- PC/TC indicator = 1
  CPT 71045 - Radiologic examination, chest; single view
  Modifier TC should be billed in the first modifier position.

- PC/TC indicator = 3
  CPT Code 93005 – ECG, routine; tracing only, without interpretation and report
  Modifier TC does not apply.

Documentation History

Type	Date	Action
Effective Date	11/20/2020	New Policy
Revised Date	10/19/2022	Modification of the examples, addition of definitions, addition of overview
Revised Date	08/16/2023	Verified links- TP

References

Government Agencies

CMS NPFS:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Supplemental Information

Definitions

Term	Definition
Modifier TC - Technical Component	The cost of the equipment supplies and personnel to perform the procedure.
CPT Modifier 26 - Professional Component	The exercise of medical judgment, including interpretation of results and a narrative report.
Global Service	A complete service/procedure where both the technical and professional components are performed by a single provider.