Modifier -26 Tip Sheet

What is Modifier -26

- Modifier -26 represents the Professional Component of procedures that contain a combination of a physician component and a technical component. Using modifier 26 identifies the physician's component (e.g. a report or interpretation).

Appropriate Usage

- To bill for only the professional component portion of a test
- To report the physician's interpretation of a test
- Procedures that have a "1" in the PCTC indicator field on the MPFSDB*
    - This is also called the Physician Fee Schedule Relative Value File. You can download it at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
    - You need the file called PPRVUXX (for the year)

- Most often, these are tests
    - Radiology
    - Anatomic laboratory tests

- Sometimes, these are procedures
    - Radiation therapy

Inappropriate Usage

- When the same provider performs both the technical and professional components, unless the same provider reports both components and the **technical portion is purchased from another provider**
- Reporting it for re-read results of an interpretation provided by another physician
- Appending it to:
    - Technical only procedure codes
    - Global test only codes
    - Professional component only codes

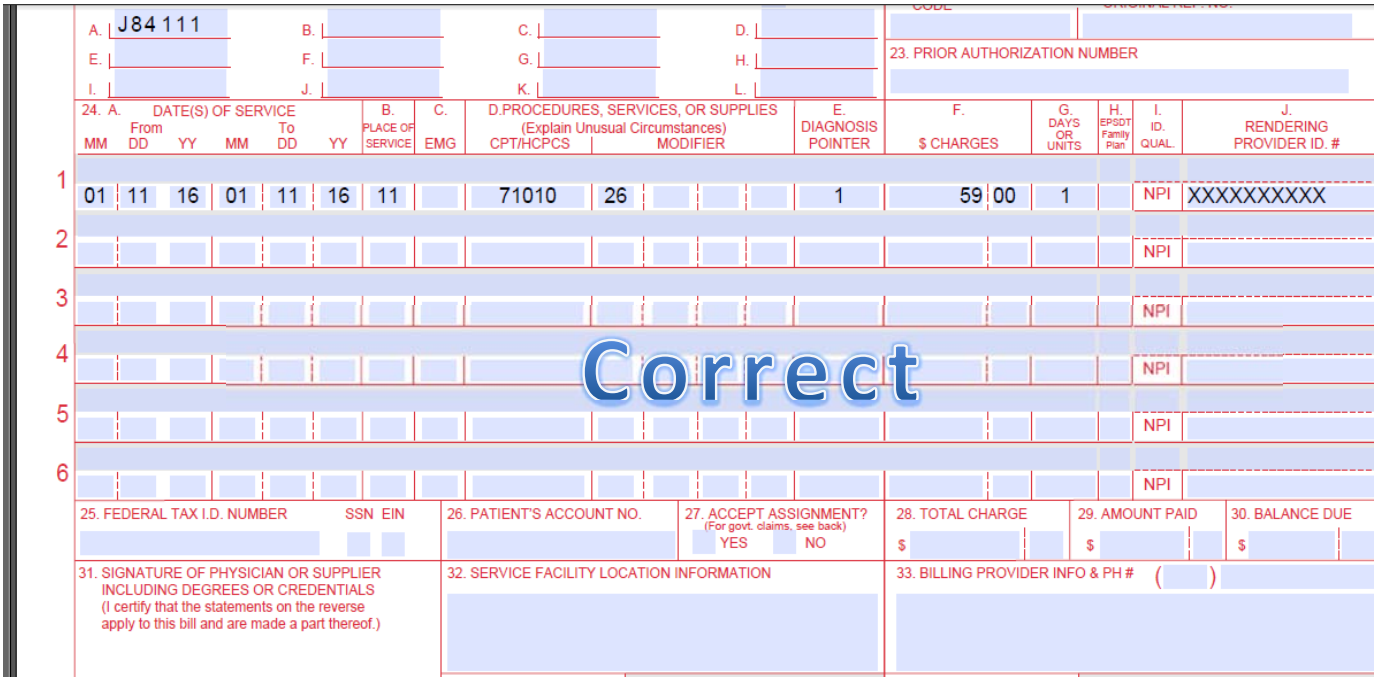
Additional Information

- Identify technical component only codes on the MPFSDB by a "3" in PC/TC. You cannot use modifier -26 if the service is technical only.
- Identify global test only codes on the MPFSDB by a "4" in PC/TC. You cannot use modifier -26 if the service is global only (it must be billed without a payment modifier).

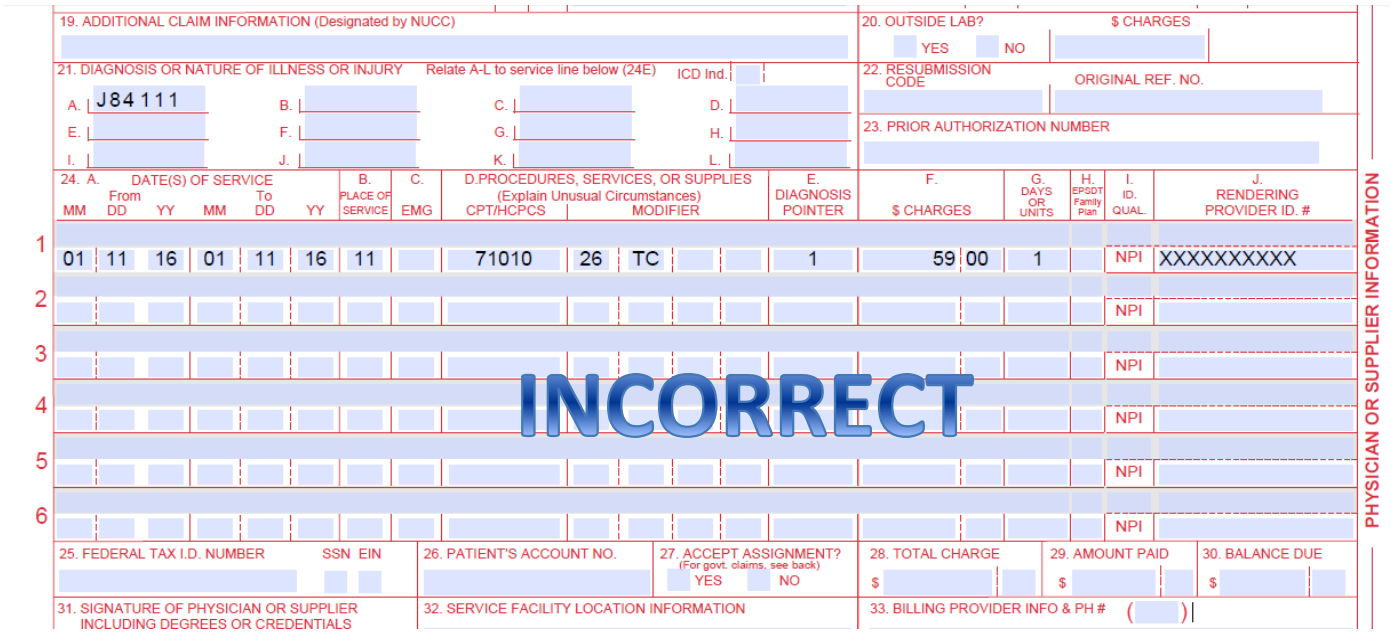
- Identify professional component only codes on the MPFSDB by a "2" in PC/TC.
- Modifier 26 is a payment modifier reportable in **the first modifier field**
- Code global services performed without modifiers**. You cannot report modifiers 26 and TC on the same procedure code on one line of service.**

Examples

The provider is billing for just the professional component on a chest X ray. This is a CORRECT use of modifier -26.



The provider is incorrectly billing for both the professional and technical services of a chest Xray on the same line. This is an incorrect use of modifier -26.



Because modifier -26 is considered a “payment” modifier, it must appear in the first modifier field for a procedure code.

Other Issues

Other reasons for modifier -26 denials (check the remark codes) are:

- If you purchased the technical component of a service, you must put the NPI of the physician you purchased the service from in field 32a of the paper claim.
- Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
- The professional component must be billed separately. You cannot bill for a global service or the two components on separate lines
- Rebill technical and professional components separately.
- Patient is entitled to benefits for Professional Services only. These are members with Part B Medicare entitlement only.

Medicare provides extensive instructions in Chapter 23 of the Claims Processing Manual, which is available on their website: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf