



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.

A. J84 111		B.		C.		D.		E.		F.		G.		H.		I.		J.			
E.		F.		G.		H.		I.		J.		K.		L.		23. PRIOR AUTHORIZATION NUMBER					
I.		J.		K.		L.		M.		N.		O.		P.		Q.		R.			
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM From DD YY		MM To DD YY				CPT/HCPCS MODIFIER				1		59 00		1				NPI		XXXXXXXXXX	
1		01 11 16 01 11 16 11				71010 26				1		59 00		1				NPI		XXXXXXXXXX	
2																		NPI			
3																		NPI			
4																		NPI			
5																		NPI			
6																		NPI			
25. FEDERAL TAX I.D. NUMBER				SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH# ()									

Correct

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.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?		\$ CHARGES					
										YES <input type="checkbox"/> NO <input type="checkbox"/>							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE		ORIGINAL REF. NO.					
A. J84111 B. C. D.																	
E. F. G. H.																	
I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPDPT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																	
1 01 11 16 01 11 16 11 71010 26 TC 1 59 00 1 NPI XXXXXXXXXX																	
2												NPI					
3												NPI					
4												NPI					
5												NPI					
6												NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH# ()							

PHYSICIAN OR SUPPLIER INFORMATION

INCORRECT

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>