Reimbursement Policy

Title: Professional and Technical Component	
Policy Number: RP20	**Applies to:** ☒ Commercial ☒ Level Funded
Effective Date: 1/1/2027	☒ Medicare Advantage ☒ Medicaid
Last Updated:	☒ Medicare Select ☒ Medicare Supplement

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines, including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities unless a specific exception is stated in the policy.

If proper coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

PC/TC Indicator: A coding system indicated on the Medicare Physician Fee Schedule Database (MPFSDB) that dictates whether a specific CPT/HCPCS code can be split into separate professional and technical components.

- **Technical Component (TC/ Modifier TC):** The portion of a diagnostic or procedural service that represents the equipment, supplies, technical staff, and other resources required to perform the service. When separately reimbursable, the technical component is identified by reporting Modifier TC.
- **Professional Component (PC/ Modifier 26):** The physician or qualified health care professional's interpretation, supervision, and report of a diagnostic or procedural service. Separate professional component billing is identified by Modifier 26.

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National Physician Fee Schedule (NPFS)- The National Physician Fee Schedule (NPFS) is the official database and comprehensive listing of payment rates, relative value units (RVUs), and policy indicators maintained by the Centers for Medicare & Medicaid Services (CMS).

Place of Service (POS): Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

Policy

This policy applies only to claims submitted on a CMS-1500 claim form. Quartz follows CMS PC/TC Indicator logic to determine eligibility for global, professional, and technical services.

Indicator	Description	Definition
0	Physician Service	Services billed as single physician service without a PC/TC
1	Diagnostic Tests	Services that contain both PC and TC Component
2	Professional Component Only	Services that contain only a professional component
3	Technical Component Only	Services that contain only a technical component
4	Global Test Only	Services that contain both PC and TC only reported globally
5	Incident-to Codes	Services included as part of a physician's professional service
6	Laboratory Physician Interpretation	Interpretation of laboratory tests containing both PC/TC
7	Physical therapy service, for which payment is not made	Services not separately payable under PC/TC billing rules.
8	Physician Interpretation	Interpretation and report without a technical component.
9	Not Applicable	Services not applicable to PC/TC component billing

Services Reported in a Facility Setting (POS codes 19, 21, 22, 23, 24, 26, 34, 51, 52, 55, 56, 57, and 61)

Reimbursement is limited to the professional component of eligible services, as the facility is responsible for furnishing the technical component.

- Reimbursement may be considered for:
  - Diagnostic tests reported with Modifier 26
  - Professional component-only codes when reported without Modifiers 26 or TC
  - Laboratory physician interpretation codes reported with Modifier 26
  - Physician Interpretation Codes when reported with a POS 21 and without Modifier 26
- Reimbursement is not eligible for:
  - Technical component-only codes
  - Global test-only codes
  - Incident-to codes

Services Reported in a Non-Facility Setting (All other POS codes not listed above)

- Reimbursement may be considered for:
  - Diagnostic tests when reported globally or separate with the appropriate modifiers (TC/26)
  - Professional component-only codes when reported without Modifiers 26 or TC
  - Technical component-only codes when reported without Modifiers 26 or TC
  - Laboratory physician interpretation codes when reported with Modifier 26

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- Reimbursement is not eligible for:
    - Incident-to codes
    - Physician Interpretation codes

Duplicate Services

Separate reimbursement for duplicate services may not be eligible when the same service is reported more than once for the same member, on the same date of service, by the same provider, or provider in same specialty, same group practice.

Separate reimbursement may be considered when reported with appropriate modifiers and documentation supports that the service was distinct, including:

- A Separate encounter on the same date of service
- A repeat procedure performed on the same date of service
- A service performed by a different practitioner
- A service performed at a separate anatomical site
- For radiology services, when using modifiers 76 or 77, please include the time of service on the claim form (or in the appropriate loop/segment of the electronic claim). This helps avoid potential duplicate denials and supports proper claim adjudication on the initial submission.

The Health Plan reserves the right to request medical records or additional documentation to support the billing of duplicate services. Documentation must demonstrate that services reported more than once represent distinct, separately reportable services and meet applicable reimbursement requirements.

Related Policies

Resources

CMS National Physician Fee Schedule (NPFS)
https://pfs.data.cms.gov/datasets

CMS National Physician Fee Schedule Relative Value File
https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files

Medicare NCCI Policy Manual
https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual

CMS Place of Service (POS) Code Set
https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Medicare Claims Processing Manual Chapters 12, 14, 16, 26
https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

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Medicare Benefit Manual Chapter 15
https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

AMA Current Procedural Terminology (CPT®), current edition
https://www.ama-assn.org/practice-management/cpt

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

Document History

10/23/2026	Document Created	Payment Integrity Department

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