



Modifier TC Fact Sheet

Definition:

- Technical Component refers to certain procedures that are a combination of a physician component and a technical component. Using modifier TC identifies the technical component.

Appropriate Usage:

- To bill for only the technical component portion of a test
- Procedures that have a "1" in the PC/TC field on the MPFSDB
- Procedures falling into the following types of service;
 - 1-Medical Care/Injections
 - 2-Surgery,
 - 4-Radiology,
 - 5-Lab,
 - 6-Radiation Therapy and
 - 8-Assistant Surgeon

Inappropriate Usage:

- When the same provider performs both the technical and professional, unless the same provider reports both components and the technical portion is purchased
- Appending it to:
 - Professional component only procedure codes identified on the MPFSDB by a "2" in the PC/TC column
 - Global test only procedure codes identified on the MPFSDB by a "4" in the PC/TC Column
 - Technical component only procedure codes identified on the MPFSDB by a "3" in the PC/TC column

Additional Information:

- Modifier 26 and TC are considered payment modifiers and must be reported in the first modifier field
- When a global service is performed, it should be coded without modifiers. Do not report a procedure code with both modifiers 26 and TC
- The payment for the technical component portion of a test includes the practice expense and the malpractice expense
- Technical component procedures are institutional and should not be billed separately by the physician in an outpatient or inpatient location



Example:

The provider is appropriately billing for just the technical portion of a screening mammogram performed on the left side.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
19. RESERVED FOR LOCAL USE										17b. NPI		FROM MM DD YY					TO MM DD YY												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E) (ICD-9-CM)										22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER																	
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. EPICOT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From MM DD YY			To MM DD YY			SERVICE		EMG		CPT/HCPCS				MODIFIER		POINTER		\$ CHARGES		DAYS OR UNITS		EPICOT Family Plan		ID. QUAL.		RENDERING PROVIDER ID. #			
1	01	04	06				11			76092	TC	LT			1	59.00		001					NPI		123456789				
2																							NPI						
3																							NPI						

The provider is incorrectly billing for both the professional and technical services of a screening mammogram, on the left side on the same line.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
19. RESERVED FOR LOCAL USE										17b. NPI		FROM MM DD YY					TO MM DD YY												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E) (ICD-9-CM)										22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER																	
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. EPICOT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From MM DD YY			To MM DD YY			SERVICE		EMG		CPT/HCPCS				MODIFIER		POINTER		\$ CHARGES		DAYS OR UNITS		EPICOT Family Plan		ID. QUAL.		RENDERING PROVIDER ID. #			
1	10	04	06				11			76092	26	TC	LT		1	59.00		001					NPI		1234567890				
2																							NPI						
3																							NPI						