UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2025R9031B

Professional/Technical Component Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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Application

This reimbursement policy applies to all Medicare Advantage products and for services reported using the 1500 Health Insurance Claim Form (a/k/a CMS 1500) or its electronic equivalent or its successor form. This policy applies to all network physicians and other qualified health care professionals.

Policy

Overview

This policy describes the reimbursement methodology for Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) codes based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File, Professional Component (PC)/Technical Component (TC) Indicators.

NPFS PC/TC Indicator	Description
0	Physician Service Codes
1	Diagnostic Tests
2	Professional Component Only Codes
3	Technical Component Only Codes
4	Global Test Only Codes
5	Incident To Codes
6	Laboratory Physician Interpretation Codes
7	Physical therapy service, for which payment may not be made
8	Physician interpretation codes
9	Not Applicable

Relative to these services, this policy also addresses information pertaining to Duplicate or Repeat Services, modifier usage, submissions based on place of service (POS), and the Professional Component with an Evaluation and Management service.

Reimbursement Guidelines

UnitedHealthcare Medicare Advantage Professional/Technical Splits

UnitedHealthcare Medicare Advantage uses the Center for Medicare and Medicaid Services' (CMS) PC/TC indicators as set forth in the "CMS Payment Policies" under the NPFS to determine whether a CPT or HCPCS procedure code is eligible for separate professional and technical services reimbursement.

CPT or HCPCS codes assigned a CMS PC/TC Indicator 1 are comprised of a Professional Component and a Technical Component which together constitute the Global Service. The Professional Component (PC), (supervision and interpretation) is reported with modifier 26, and the Technical Component (TC) is reported with modifier TC.

The term “professional/technical split” is used to reference a Global Service assigned a PC/TC Indicator 1 that may be “split” into a Professional Component and a Technical Component. CPT or HCPCS codes assigned a PC/TC Indicator 1 is listed in the NPFS. Each Global Service is listed on a separate row followed immediately by separate rows listing the corresponding Technical Component and Professional Component.

CPT or HCPCS codes with CMS PC/TC indicators 0, 2, 3, 4, 5, 7, 8, and 9 are not considered eligible for reimbursement when submitted with modifiers 26 and/or TC.

CPT or HCPCS codes with CMS PC/TC indicator 6 are not considered eligible for reimbursement when submitted with modifier TC.

CMS publishes this information in the "Physician Fee Schedule, PFS Relative Value Files" page, accessible through the following website:

Physician Fee Schedule Relative Value Files

UnitedHealthcare Medicare Advantage's percentage splits are developed on a national level from the CMS **Non-Facility Total** Resource-Based Relative Value Scale (RBRVS) based percentage splits. UnitedHealthcare Medicare Advantage's splits are updated quarterly and differ no more than 2.5% (for each CPT and HCPCS code) from the CMS **Non-Facility** Total RBRVS based percentage splits which are found in the NPFS.

Services assigned a PC/TC Indicator 1 that CMS indicates may be carrier-priced, or those for which CMS does not develop RVUs are considered Gap Codes.

Gap Fill Codes: When data is available for Gap Codes, UnitedHealthcare Medicare Advantage uses the relative values published in the first quarter update of the Optum *The Essential RBRVS* publication for the current calendar year.

Gap Codes that are eligible for PC/TC reimbursement per CMS but do not have RVUs established, or data available for gap fill, are included in the "Codes Subject to the CMS PC/TC Concept Without RVU Splits" lists below and are allowed at 100% of the Allowable Amount for both the Professional Component and Technical Component.

For additional information refer to the Questions and Answers section, Q&A #1.

Reimbursement Amounts for Professional/Technical Splits

The Professional Component and Technical Component reimbursement for PC/TC split eligible services is calculated at a percentage of the Global Service Allowable Amount, except when provided otherwise by a physician or other qualified health care professional contract. When a contract applies, payments for PC/TC split eligible services are based on specific professional and technical fees contained within the contract's fee schedules or are paid at the percentage of charge level in the fee schedule. (Physicians and other qualified health care professionals contracted at a percent of charge do not have further PC/TC reductions for PC/TC split eligible services unless it is specifically stated in their contracts.)

When eligible for reimbursement, Professional Component/Technical Component codes with a CMS PC/TC Indicator 2, 3, 4, 5, 6, or 8 are reimbursed at 100% of the Allowable Amount.

For additional information, refer to the Questions and Answers section, Q&A #2.

Reimbursement for Professional/Technical Component Based on POS

Reimbursement of the Professional Component, the Technical Component, and the Global Service for codes assigned a PC/TC Indicator 1, 2, 3, 4, 5, 6, 8 or 9 subject to the PC/TC concept according to the NPFS are based upon physician and other qualified health care professional specialty and CMS POS code set, as described below.

CMS POS Code Set

The edits administered by this policy may be found on the following link using the appropriate year and quarter referencing the “PCTC IND” column:

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

For the purposes of this policy, a facility POS reported on a CMS-1500 claim form is considered POS 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 56, and 61. All other POS are considered non-facility.

Claims Reported on a CMS-1500 with a Facility POS

For Services Furnished in a Facility POS 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 56, or 61

Any services that are provided in a facility POS and that are subject to the PC/TC concept or that have both a Professional Component and a Technical Component according to the CMS PC/TC indicators, UnitedHealthcare Medicare Advantage will reimburse the interpreting physician or other qualified health care professional only the Professional Component as the facility is reimbursed for the Technical Component of the service. To be considered for Professional Component reimbursement, a service or procedure must have a:

- CMS PC/TC Indicator 1, and must be reported with modifier 26;
- CMS PC/TC Indicator 2 (Professional Component Only Codes), and must be reported without modifier 26 or TC; or
- CMS PC/TC Indicator 6 (Laboratory Physician Interpretation Codes) and must be reported with modifier 26.
- CMS PC/TC Indicator 8 (Physician Interpretation Codes) and be reported without modifier 26.

For PC/TC Indicator 8 Codes Furnished in a POS Other than POS 21

The CMS NPFS guidelines advise that payment should not be recognized for PC/TC Indicator 8 codes, which are defined as physician interpretation codes, furnished to patients in the outpatient or non-hospital setting (POS other than 21).

In alignment with CMS, UnitedHealthcare Medicare Advantage will not reimburse PC/TC Indicator 8 (CPT code 85060) when reported by a physician or other qualified health care professional with a CMS POS code other than inpatient hospital (POS 21).

When a physician or other qualified health care professional provides the equipment to perform the service or procedure in a facility POS, only the facility may be reimbursed for the Technical Component of the service or procedure. Based on the CMS PC/TC indicators, UnitedHealthcare Medicare Advantage considers the Technical Component to be a service or procedure that has a:

- CMS PC/TC Indicator 1 (Diagnostic Test), and is reported with modifier TC; or
- CMS PC/TC Indicator 3 (Technical Component Only Codes)

Non-Allowed Services Furnished in a Facility POS

Consistent with CMS, UnitedHealthcare Medicare Advantage will not reimburse physicians and other qualified health care professionals for "Incident To" codes identified with a CMS PC/TC indicator 5 when reported in a facility POS regardless of whether a modifier is reported with the code. In addition, CPT coding guidelines for many of the PC/TC Indicator 5 codes specify that these codes are not intended to be reported by a physician in a facility setting.

UnitedHealthcare Medicare Advantage will not reimburse physicians or other qualified health care professionals for services with a CMS PC/TC Indicator 4 (stand-alone Global Test Only Codes) when rendered in a facility POS. Codes with a PC/TC indicator 4 identify Stand-alone Codes that describe selected diagnostic tests for which there are separate associated codes that depict the Professional Component only (PC/TC indicator 2) and Technical Component only (PC/TC indicator 3).

UnitedHealthcare Medicare Advantage utilizes the CMS National Physician Fee Schedule (NPFS) PC/TC Indicators 3 or 9 to identify laboratory services that are not reimbursable to a Reference Laboratory or Non-Reference Laboratory in a facility setting.

UnitedHealthcare Medicare Advantage will not reimburse a Professional Component when a diagnostic laboratory service is provided either manually or with automated equipment, as these codes are not subject to the PC/TC concept or are Technical Component only codes. UnitedHealthcare Medicare Advantage follows CMS PC/TC indicators in determining which services do not qualify for Professional Component reimbursement:

- CMS PC/TC Indicator 3 (Technical Component Only Codes)
- CMS PC/TC Indicator 9 (PC/TC Concept Not Applicable)

For services with a CMS PC/TC indicator 7 (physical therapy service, for which payment may not be made), UnitedHealthcare Medicare Advantage will not reimburse the physician or other qualified health care professional when rendered in a facility POS. PC/TC indicator 7 codes are specific to services of privately practicing therapists. When therapy services are provided by privately practicing physical therapists, occupational therapists, or speech-language

pathologists to a hospital inpatient or hospital outpatient, UnitedHealthcare Medicare Advantage will not reimburse the physician or other qualified health care professional.

Claims Reported on a CMS-1500 with a Non-Facility POS

For Services Furnished in a Non-Facility POS (POS other than 19, 21, 22, 23, 24, 26, 31, 34, 51, 52, 55, 56, 57 or 61)
For services assigned a PC/TC Indicator 1 according to CMS, and provided in a non-facility POS, UnitedHealthcare Medicare Advantage will consider reimbursement of the Professional Component and the Technical Component when eligible.

For Services Furnished in a Mobile Unit
Services furnished in a mobile unit are often provided to serve an entity for which another POS code exists. When this is the case, the POS for that entity should be reported. For example, a mobile unit may be sent to a facility. Since the mobile unit is serving an entity for which a facility POS already exists, the POS code 21 (inpatient hospital) for that location should be reported. However, if the mobile unit is not serving an entity which could be described by an existing POS code, report POS 15 (mobile unit).

Note: When intraoperative neuromonitoring (IONM) services (95940 and G0453) and associated study codes are reported in a facility POS, the Technical Component will be denied.

PC/TC Indicator 1 Codes
For codes included in the ASCFS Addendum BB PC/TC Indicator 1 Codes list, only the Professional Component (PC, modifier 26) will be reimbursed.

- When reported globally (no modifier), the Technical Component of the code will not be reimbursed.
- When reported with modifier TC, the code will not be reimbursed.

Drug Administration Codes
According to the CMS National Correct Coding Initiative (NCCI) Policy Manual, drug administration codes CPT 96360-96379, 96401-96425, and 96521-96523 are considered included in the facility payment when reported in POS 24.

In alignment with CMS, UnitedHealthcare Medicare Advantage will not reimburse drug administration codes 96360-96379, 96401-96425, and 96521-96523 reported by a physician or other health care professional in POS 24.

Duplicate or Repeat Services for Professional/Technical Eligible Codes

This section of the policy applies to when Duplicate or Repeat Services are reported by the same physician or other qualified health care professional. Duplicate or Repeat Services are defined as identical CPT or HCPCS codes assigned a PC/TC indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient for the same date of service on separate claim lines or on different claims regardless of the assigned Medically Unlikely Edits (MUE) value.

For services that have both a Professional Component and a Technical Component reported separately, UnitedHealthcare Medicare Advantage will also review the submission of modifier 26 and TC appended to the code(s) to identify whether a Duplicate or Repeat Service has been reported.

Should the Same Individual Physician or Other Qualified Health Care Professional report the Professional Component (modifier 26) and the Technical Component (modifier TC) for the same PC/TC Indicator 1 service separately, UnitedHealthcare Medicare Advantage will consider both services eligible for reimbursement unless subject to other portions of this policy.

Modifiers offer specific information and should be used appropriately. Separate consideration will be given to duplicate or repeat multiple submissions of the same code when the appropriate modifier is appended to the Duplicate or Repeat Service with one of the following modifiers:

59	76	77	91	E1	E2	E3	E4	FA	F1
F2	F3	F4	F5	F6	F7	F8	F9	LC	LD

LM	LT	RC	RI	RT	TA	T1	T2	T3	T4
T5	T6	T7	T8	T9	XE	XP	XS	XU	

For additional information, refer to the Questions and Answers section, Q&A #3.

UnitedHealthcare Medicare Advantage follows a "first in, first out" claim payment methodology in determining which claim will be considered for reimbursement when claims for Duplicate or Repeat Services are received.

- When the Same Individual Physician or Other Qualified Health Care Professional reports the Global Service (PC/TC Indicator 1)
  - or a stand-alone service (PC/TC Indicator 2, 3, or 4) more than once and on separate lines, separate consideration will only be given to those services reported with the appropriate modifier. Otherwise, the second and subsequent services received will not be separately reimbursed.
  - and a modifier 26 or TC for the same service for the same member on the same date of service, separate consideration will only be given to those services reported with the appropriate modifier. Otherwise, the second and subsequent services received will not be separately reimbursed.
- When the same PC/TC Indicator 6 or 8 service is reported more than once and on separate lines by the same physician or other qualified health care professional, separate consideration will only be given to those services reported with modifier 59, XE, XP, XS, XU or 91. Otherwise the second and subsequent services received will not be separately reimbursed.
- When a PC/TC 4 service is billed with a PC/TC 2 or 3 service for the same member, same date of service and by the same provider; then the second and subsequent service billed will be denied unless billed with an appropriate modifier.

Professional Component with an Evaluation and Management Service

With the exception of radiologic codes that describe fluoroscopic or ultrasonic guidance for placement of a needle, catheter, or tube, UnitedHealthcare considers the interpretation (modifier 26) of a radiology service assigned a PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other QHP on the same date of service for the same patient as these services usually are not distinct from the E/M service when both are rendered on the same day. However, if the provider submits a written radiology interpretation report for a radiology service appended with modifier 26, it may be considered for additional reimbursement. (See the Radiological Codes Requiring Attached Report list)

American College of Radiology (ACR) guidelines suggest that physicians and other qualified health care professionals who believe the Professional Component (modifier 26) for a PC/TC Indicator 1 radiology code is reimbursable in addition to the E/M service on the same day include the following information in the medical record:

Procedures and materials

- The report or record should include a description of the studies and/or procedures performed and any contrast media and/or radiopharmaceuticals (including specific administered activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere.

Findings

- The report or record should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings.

Impression

- Conclusion or diagnosis

For additional information, refer to the Questions and Answers section, Q&A #6 & #7.

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
Duplicate or Repeat Services	Identical CPT or HCPCS codes assigned a PC/TC indicator 1, 2, 3, 4, 6 or 8 submitted by the same provider for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Medically Unlikely Edits (MUE) value.
Gap Code	A CPT or HCPCS code for which CMS does not develop RVUs. Note: Under the Professional/Technical Component Policy a Gap Code has a CMS PC/TC Indicator 1 assignment.
Gap Fill Code	A Gap Code that UnitedHealthcare Medicare Advantage uses relative values based on the first quarter update of the Optum *The Essential RBRVS* publication for the current calendar year.
Global Service	A Global Service includes both a Professional Component and a Technical Component. When a physician or other qualified health care professional bills a Global Service, he or she is submitting for both the Professional Component and the Technical Component of that code. Submission of a Global Service asserts that the Same Individual Physician or Other Health Care Professional provided the supervision, interpretation and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. In appropriate circumstances, the Global Service is identified by reporting the appropriate professional/technical split eligible procedure code with no modifier attached or by reporting a standalone code for global test only services.
Professional Component	The Professional Component represents the physician or other health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other health care professional supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative report to be included in the patient's medical record, and directly contributes to the patient's diagnosis and/or treatment. In appropriate circumstances, it is identified by appending modifier 26 to the designated procedure code or by reporting a stand-alone code that describes the Professional Component only of a selected diagnostic test.
Relative Value Unit (RVU)	The assigned unit value of a particular CPT or HCPCS code. The associated RVU is from CMS NPFS Non-Facility Total value.
Resource-Based Relative Value Scale (RBRVS)	Payment schedule based on the relative values of services provided. The current RBRVS system ranks services according to the relative costs required to provide them. These costs are defined in terms of units, with more complex, more time-consuming services having higher unit values than less complex, less time-consuming services. Furthermore, each service is compared to all other physician services so that each service is given a value that reflects its cost or value when compared to all other physician services.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same National Provider Identifier (NPI) number.
Stand-alone Code	A Stand-alone Code describes a specific component of a selected diagnostic test. There is an associated code that describes the Professional Component only of the diagnostic

	test, an associated code that describes the Technical Component only, and another associated code that describes the global test only. An example is the series of codes used to describe electrocardiograms with at least 12 leads. CPT code 93010 describes the Professional Component only, 93005 describes the Technical Component only, and 93000 describes the global test only. Modifiers TC or 26 are not used to report these services as they are inherent within the code descriptions.
Technical Component	The Technical Component is the performance (technician/equipment/facility) of the procedure. In appropriate circumstances, it is identified by appending modifier TC to the designated procedure code or by reporting a Standalone Code that describes the Technical Component only of a selected diagnostic test.

Questions and Answers	
1	**Q:** Are the CMS Geographic Practice Cost Indices by Medicare Carrier and Locality considered when developing United Healthcare Medicare Advantage percentage splits? **A:** No. The UnitedHealthcare Medicare Advantage percentage splits are developed on a national level from the CMS Resource-Based Relative Value Scale (RBRVS) percentage splits.
2	**Q:** If a physician or health care professional is contracted with specific rates for the Professional Component and the Technical Component, will their contracted rates be updated quarterly to reflect changes in CMS professional and technical rates? **A:** No. As their fees for the Professional Component and the Technical Component determined by their contract, the physician or health care professional will not be impacted by United Healthcare Medicare Advantage's quarterly updates to the percentage calculation methodology for Professional Component and Technical Component reimbursement.
3	**Q:** When does UnitedHealthcare Medicare Advantage give consideration for repeat procedures by the same individual physician, another physician or other health care professional when reported with modifiers 76 or 77? **A:** Repeat procedures must be identified with modifiers 76 or 77 as appropriate to indicate that subsequent procedures were performed at different episodes on the same day. Modifiers 76 or 77 should not be used to report multiple interpretations by the same or different physicians or other health care professionals for the same EKG or x-ray procedure for quality control purposes. However, when subsequent interpretations of the same procedure show a different finding that alters/contributes to the diagnosis and treatment of the patient, use of modifier 76 or 77 is appropriate. Note: It is inappropriate to use modifier 76 or 77 to indicate repeat laboratory services. Modifiers 59, XE, XP, XS, XU or 91 should be used to indicate repeat or distinct laboratory services, as appropriate according to the AMA and CMS. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76 or 77.
4	**Q**: There is a series of electrocardiogram CPT codes where one code describes the Professional Component only of the diagnostic test (e.g., CPT code 93010; PCTC Indicator = 2), an associated code that describes the Technical Component only (e.g., CPT code 93005; PCTC Indicator = 3), and another associated code that describes the global tests only (e.g., CPT code 93000; PCTC Indicator = 4). Does duplicate repeat editing apply to this code series? **A:** Yes. Modifiers 26 or TC are not used to report these services as the intent is inherent within the code descriptions. If the global test is received first, then the component code(s) will be denied. If a component code is received first, then the global test will be denied.
5	**Q:** Are the Technical Component services that are reported with modifier SG on a CMS-1500 reimbursed as a facility claim?

	A: Yes, claim lines reported with modifier SG indicate a facility charge and are reimbursed as a facility claim.
6	**Q**: If the Same Individual Physician or Other QHP reports modifier 59, XE, XP, XS or XU in addition to modifier 26 on a PC/TC Indicator 1 code, e.g., 70110-26-59, to indicate that it is a separate and distinct service from their E/M service performed on the same date, will UnitedHealthcare consider separate reimbursement for the radiology interpretation? **A**: As outlined in the "Professional Component with an Evaluation and Management Service" section of this policy, UnitedHealthcare requires submission of a distinctly identifiable signed written radiological report separate from the E/M service performed, even when modifier 59, XE, XP, XS or XU is reported, before separate reimbursement for the radiology interpretation will be considered.
7	**Q:** If the Same Individual Physician or Other QHP reports an E/M code with modifier 25 on the same day as their radiology interpretation appended with modifier 26, will the requirement of submitting supporting documentation for the radiology interpretation be bypassed? **A:** No, per CPT guidelines, modifier 25 is reported to identify a separate and distinct E/M service. In this scenario, it is the radiology interpretation that requires documentation for separate reimbursement.

Codes

National Physician Fee Schedule Relative Value File

Attachments

Professional Technical Component Policy Modifiers **Professional Technical Component Policy Modifiers**	A list of modifiers that may be reported along with PC/TC codes. Some of the modifiers in this list may not be appropriate for all of the PC/TC codes.
Gap Fill Codes **Gap Fill Codes**	A list of PC/TC Indicator 1 Diagnostic Test codes subject to the CMS PC/TC component concept, for which CMS does not develop RVUs or which CMS states may be carrier-based. These are assigned gap fill RVUs from data published by CMS Carriers or are otherwise assigned RVUs by UnitedHealthcare Medicare Advantage.
Radiological Codes Requiring Attached Report **Radiological Codes Requiring Attached Report**	A list of PC/TC Indicator 1 radiology codes appended with modifier 26 requiring the submission of a written interpretation radiology report when billed with an E/M service.

Resources

www.cms.gov

CMS Place of Service Code Set

American Medical Association (AMA) Current Procedural Terminology (CPT®)

Centers for Medicare and Medicaid Services, (PFS) Relative Value Files

Medicare Benefit Policy Manual - Chapter 01 - Inpatient Hospital Services Covered Under Part A: Section 30.4 & 30.5

Medicare Benefit Policy Manual - Chapter 06 - Hospital Services Covered Under Part B: Sections 10.1, 20,2

Medicare Claims Processing Manual – Chapter 12 – Physicians/Nonphysician Practitioners: Sections 20.2, 30, 60

Medicare Claims Processing Manual - Chapter 13 - Radiology Services and Other Diagnostic Procedures: Sections 20.1, 20.2.1, 90.1, 90.2, 110.3, 150

Medicare Claims Processing Manual - Chapter 16 - Laboratory Services: Sections 40.4, 40.4.1, 40.8, 120.1

Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements: Sections 20.9.1.1, 30

National Correct Coding Initiative Chapter 1

National Correct Coding Initiative Chapter 11

Optum, "*The Essential RBRVS*," 1st Quarter Update

History	
4/3/2025	Policy Version Change Reimbursement Guidelines: Remove POS 55,57 History section: Entries prior to 4/3/2025 archived
1/26/2025	Policy Version Change Attachments Section: Updated Gap Fill Codes list
10/1/2024	Policy Version Change Attachments Section: Added Radiological Codes Requiring Attachment Questions and Answers Section Update: Added Q&A #6 and #7 History section: Entries prior to 10/1/2022 archived
5/1/2024	Policy Version Change Attachments Section: Replaced URL with embedded document History section: Entries prior to 5/1/2022 archived
8/21/2023	Definition Section: Updated Policy Version Change History section: Entries prior to 8/1/2021 archived
5/1/2023	Logo Updated History section: Entries prior to 5/1/2021 archived
12/13/2017	Policy approved by the Reimbursement Policy Oversight Committee