PROFESSIONAL/TECHNICAL COMPONENT POLICY (CES)

Policy Number: ADMINISTRATIVE 271.4 T0 **Effective Date**: October 1, 2020

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Related Policies

- Refer to the Reimbursement Guidelines section of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This reimbursement policy applies to 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 and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

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.

CMS NPFS PC/TC Indicator	Description
0	Physician Service Codes
1	Diagnostic Tests

CMS NPFS PC/TC Indicator	Description
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.

Unless otherwise specified, for the purposes of this policy, Same Individual Physician or Other Qualified Health Care Professional is defined as the same individual rendering health care services reporting the same Federal Tax Identification number.

REIMBURSEMENT GUIDELINES

Oxford Professional/Technical Splits

Oxford uses the Center for Medicare and Medicaid Services' (CMS) NPFS PC/TC indicators as set forth in the "CMS Payment Policies" under the National Physician Fee Schedule Relative Value File 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 NPFS 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 CMS NPFS 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 are listed in the National Physician Fee Schedule Relative Value File. 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 NPFS 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 NPFS PC/TC Indicator 6 are not considered eligible for reimbursement when submitted with modifier TC.

CMS publishes this information in the Physician Fee Schedule Relative Value Files page.

Oxford's percentage splits are developed on a national level from the CMS Non-Facility Total Resource-Based Relative Value Scale (RBRVS) based percentage splits. Oxford'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. The current splits are attached to this policy in the next section.

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

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

Gap Fill Codes

When data is available for Gap Codes, Oxford uses the relative values published in the first quarter update of the Optum *The Essential RBRVS* publication for the current calendar year. Refer to the Gap Fill Codes list.

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 PC/TC Concept Without RVU Splits list below and are allowed at 100% of the Allowable Amount for both the Professional Component and Technical Component.

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. Refer to the Professional/Technical Component Split Codes (CMS NPFS PC/TC Indicator 1 Diagnostic Tests) list.

When eligible for reimbursement, Professional Component/Technical Component codes with a CMS NPFS PC/TC Indicator of 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 CMS NPFS PC/TC Indicator 1, 2, 3, 4, 5, 6, 8 or 9 subject to the PC/TC concept according to the National Physician Fee Schedule Relative Value File are based upon physician and other qualified health care professional specialty and CMS POS Code Set, as described below.

For the purposes of this policy, a facility POS is considered POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 and 61. All other POS are considered non-facility.

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 physician's office. Since the mobile unit is serving an entity for which an office POS already exists, the POS code 11 (office) 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).

For CMS NPFS 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 CMS NPFS 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, Oxford will not reimburse CMS NPFS 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).

For Services Furnished in a Facility POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57, or 61

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

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 NPFS PC/TC Indicators, Oxford considers the Technical Component to be a service or procedure that has a:

- CMS NPFS PC/TC Indicator 1 (Diagnostic Test), and is reported with modifier TC; or
- CMS NPFS PC/TC Indicator 3 (Technical Component Only Codes) and is reported without modifier TC.

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.

For Services Furnished in a Non-Facility POS (POS other than 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57, or 61)

For services assigned a CMS NPFS PC/TC Indicator 1 and provided in a non-facility POS, Oxford will consider reimbursement of the Professional Component and the Technical Component when eligible.

Non-Allowed Services Furnished in a Facility POS

Consistent with CMS, Oxford will not allow reimbursement to physicians and other qualified health care professionals for "Incident To" codes identified with a CMS NPFS 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 CMS NPFS PC/TC Indicator 5 codes specify that these codes are not intended to be reported by a physician in a facility setting.

For services with a CMS NPFS PC/TC Indicator 4 (Standalone Global Test Only Codes), Oxford will not reimburse the physician or other qualified health care professional when rendered in a facility POS. Global Test Only Codes with a CMS NPFS PC/TC Indicator 4 identify Standalone Codes that describe selected diagnostic tests for which there are separate associated codes that depict the Professional Component only (CMS NPFS PC/TC Indicator 2) and Technical Component only (CMS NPFS PC/TC Indicator 3).

Oxford utilizes the CMS 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.

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

Oxford 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. Oxford follows CMS NPFS PC/TC Indicators in determining which services do **not** qualify for Professional Component reimbursement:

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

Refer to the list of Laboratory Codes with a CMS NPFS PC/TC Indicator 3 or 9.

Note: Oxford will make an exception to this policy for reproductive medicine procedures 89250-89398 when the facility laboratory is not equipped to perform these specialized services and refers them to a reproductive laboratory. In the event that both a facility and a Reference Laboratory report the same service on the same day for the same member, only the facility laboratory may be reimbursed.

Services Reported in a CMS POS 24 (Ambulatory Surgical Center)

Consistent with CMS guidelines, Oxford will not reimburse physicians or other qualified health care professionals for the Technical Component of services included in the Ambulatory Surgery Center Fee Schedule (ASCFS) Addendum BB and reported with a CMS POS 24 as the ambulatory surgical center (ASC) is reimbursed for the Technical Component.

The Technical Component of services reported on a CMS-1500 claim form with an SG modifier (Ambulatory surgical center [ASC] facility service) is not reimbursed as a professional claim. Claim lines reported with modifier SG indicate a facility charge and are reimbursed as a facility claim.

CMS NPFS PC/TC Indicator 1 Codes

For codes included in the ASCFS Addendum BB CMS NPFS PC/TC Indicator 1 and Indicator 3 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.

CMS NPFS PC/TC Indicator 3 Codes

Codes included in the ASCFS Addendum BB CMS NPFS PC/TC Indicator 1 and Indicator 3 Codes list will not be reimbursed as they represent Technical Component services only.

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, Oxford will not reimburse drug administration codes 96360-96379, 96401-96425, and 96521-96523 reported by a physician or other qualified 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 or different physician or other qualified health care professional. When services are eligible for reimbursement under this policy, only one physician or other qualified health care professional will be reimbursed when Duplicate or Repeat Services are reported. Duplicate or Repeat Services are defined as identical CPT or HCPCS codes assigned a CMS NPFS PC/TC Indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) value.

For services that have both a Professional Component and a Technical Component (i.e., CMS NPFS PC/TC Indicator 1, Diagnostic Tests) Oxford will also review the submission of modifier 26 and TC appended to the code 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 CMS NPFS PC/TC Indicator 1 service separately, Oxford 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:

Modifier										
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.

Oxford 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 CMS NPFS PC/TC Indicator 1 service (no modifier) or a Standalone 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.
- When the same CMS NPFS PC/TC Indicator 6 or 8 service is reported more than once and on separate lines by the same or different 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 reported will not be separately reimbursed.
- When the Same Individual Physician or Other Qualified Health Care Professional reports the global CMS NPFS PC/TC Indicator 1 service (no modifier) 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 will not be separately reimbursed.
- When the same CMS NPFS PC/TC Indicator 1 service is reported globally (no modifier) by different physicians or other qualified health care professionals on the same date or service for the same member, Oxford will only consider separate reimbursement for the second claim when reported with an appropriate modifier. Otherwise, the second and subsequent services received will not be separately reimbursed.
- When the same CMS NPFS PC/TC Indicator 1 service is reported globally (no modifier) by one physician or other qualified health care professional, and a different physician or other qualified health care professional reports modifier 26 or TC for the same service for the same member on the same date of service, Oxford will consider separate reimbursement for the second claim when reported with an appropriate modifier. Otherwise, the second and subsequent services will not be separately reimbursed.
- When a CMS NPFS PC/TC Indicator 4 service is billed with a CMS NPFS PC/TC Indicator 2 or 3 service for the same member, same date of service, and by the same or different provider; then the second and subsequent service billed will be denied unless billed with an appropriate modifier.

For example:

- If the claim for the physician reporting the Global Service is received first and allowed, the subsequent claim received by a different physician for a single component (i.e., Professional Component or Technical Component) will be denied as duplicate.
- If the claim for the physician reporting the Professional Component (modifier 26) service is received first and allowed, the subsequent claim received by a different physician for the Global Service will be reimbursed only for the Technical Component.

- If the claim for the physician reporting the Technical Component (modifier TC) service is received first and allowed, the subsequent claim received by a different physician for the Global Service will be reimbursed only for the Professional Component.

Refer to the Oxford *Maximum Frequency per Day* policy for additional information on assigned MFD values.

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, Oxford considers the interpretation (modifier 26) of a radiology service assigned a CMS NPFS PC/TC Indicator 1 to be included in the Evaluation and Management (E/M) service when performed by the Same Individual Physician or Other Qualified Health Care Professional 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 provided on the same day.

American College of Radiology (ACR) guidelines suggest that physicians and other qualified health care professionals who believe the Professional Component (modifier 26) for a CMS NPFS 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 radio-pharmaceuticals (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

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 CMS NPFS PC/TC Indicator 1, 2, 3, 4, 6, or 8 submitted for the same patient on the same date of service on separate claim lines or on different claims regardless of the assigned Maximum Frequency per Day (MFD) 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 NPFS PC/TC Indicator 1 assignment.

Gap Fill Codes: Codes for which CMS does not develop RVUs. Relative values are therefore assigned based on the first quarter update of 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 Qualified 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.

Independent Laboratory: An Independent Laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital. An Independent Laboratory must meet Federal and State requirements for certification and proficiency testing under the Clinical Laboratories Improvement Act (CLIA).

Non-Reference Laboratory: A physician or a Pathologist reporting laboratory procedures performed in their office.

Pathologist: A Pathologist is a physician who specializes in diagnosing diseases by examining tissue, blood, and body fluids using advanced laboratory techniques.

Professional Component: The Professional Component represents the physician or other qualified health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other qualified 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 Standalone code that describes the Professional Component only of a selected diagnostic test.

Reference Laboratory: A Reference Laboratory that receives a Specimen from another, Referring Laboratory for testing and that actually performs the test is often referred to as an Independent Laboratory. Services billed by a Reference Laboratory should use modifier 90 to identify the Reference Laboratory services.

Relative Value Unit: 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: 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 Federal Tax Identification number.

Specimen: Tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathological diagnosis. Two or more such Specimens from the same patient (e.g., separately identifiable endoscopic biopsies, skin lesions) are each appropriately assigned an individual code reflective of its proper level of service.

Standalone Code: A Standalone 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 Oxford percentage splits?
	A:	No. The Oxford 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 other qualified 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 other qualified health care professional will not be impacted by Oxford's quarterly updates to the percentage calculation methodology for Professional Component and Technical Component reimbursement.

3	Q:	When does Oxford give consideration for repeat procedures by the same individual physician, another physician or other qualified 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 qualified 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; CMS NPFS PC/TC Indicator = 2), an associated code that describes the Technical Component only (e.g., CPT code 93005; CMS NPFS PC/TC Indicator = 3), and another associated code that describes the global tests only (e.g., CPT code 93000; CMS NPFS PC/TC Indicator = 4). Does duplicate 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:	When a patient is in an outpatient or inpatient hospital setting and a mobile unit furnishes a service in conjunction with the hospital service, what place of service may the mobile unit report?
	A:	When a mobile unit is serving an entity for which a facility POS already exists, certain services should be reported with POS 15 only if a facility claim has not been submitted or received for the same date of service. Services with a technical component performed in a facility setting are deemed included in the global payment to the facility and are not separately reimbursable when reported by a physician or other qualified health care professional.

APPLICABLE CODES

CPT/HCPCS Codes

Refer to the list of Professional/Technical Component Policy (CES): CPT/HCPCS Codes.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [2020R0012B]

American College of Radiology – ACR Practice Guideline for Communication of Diagnostic Imaging Findings: http://www.acr.org/Quality-Safety/Standards-Guidelines/Practice-Guidelines-by-Modality

American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

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

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2020	**Applicable Codes** • Updated list of *Laboratory Codes (CMS NPFS PC/TC Indicator 3 or 9)* to reflect quarterly edits; added CPT code 87426 **Supporting Information** • Archived previous policy version ADMINISTRATIVE 271.3 T0