Modifier 26 Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Modifier 26, defined as "Professional Component," should be added to a procedure code when the provider delivers only the professional aspect of the service.

Global Service

A global service/procedure is when both technical and professional components are performed by one provider.

Modifier 26 indicates only the professional component of a service/procedure, typically billed by a physician. Services with a value of "1" or "6" in the PC/TC Indicator field of the National Physician Fee Schedule can be billed with modifier 26, including radiology, pathology, laboratory, and medicine services.

- Value "1" services are diagnostic tests with both components. In hospitals, the TC component is presumed to be billed by the facility; thus, modifier 26 is for the professional component.
- Value "6" services are clinical lab tests where separate payment for physician interpretation is allowed. Modifier 26 should be used for these interpretations. Do not use modifier TC for these codes.
- For global services, do not use modifiers TC and 26. No modifier is needed.
- Always bill modifier 26 in the first modifier position.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
CPT Modifier 26	Professional Component- The exercise of medical judgment, including interpretation of results and a narrative report.

HCPCS Level II Modifier TC	Technical Component- The cost of the equipment supplies and personnel to perform the procedure.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	11/20/2020	New Policy
Revised Date	10/19/2023	Reviewed Links
Revised Date	08/16/2023	Verified Links
Revised Date	12/12/2024	Updated Template Verified Links
Revised Date	08/21/2025	Changed entire document to 10 point font; added page number and PI number

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
AAPC (American Academy of Professional Coders)	When to Apply Modifiers 26 and TC - AAPC Knowledge Center
CMS	Medicare Claims Processing Manual CH 23

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*