Global Radiology Procedure Billing Guide

Last revised: September 2025

Scope and history

This policy applies to healthcare providers who submit claims for services that are eligible to be billed separately under both the professional and technical components. It establishes guidelines for appropriate coding and compliance with regulatory requirements.

Certain services and procedures are usually reported by a single CPT code, but sometimes codes can be described by two separate portions: a professional component (26) and a technical component (TC). This is most common with diagnostic procedures such as radiology, stress testing, cardiac catheterization, etc.

CareOregon has identified claims that contain services that are eligible for billing technical and professional components that were billed both globally and with a modifier, which can result in denials and/or incorrect reimbursement.

Policy/guidelines

- Modifier 26: The professional component of a procedure is indicated by appending modifier 26 to the code. The professional component of a procedure may include interpretation and a written report. Modifier 26 should be used if the provider only performs a portion of the test and uses the equipment owned by a hospital/facility.

  Inappropriate usage of modifier 26 is when the provider performs both the technical and professional component, reports it to re-read results of an interpretation provided by another provider, appends it to global test-only codes, professional component only codes, technical component only codes.

- Modifier TC: The technical component encompasses the allocation of equipment, supplies, personnel, and associated costs necessary for the execution of a procedure. To bill exclusively for the technical component, the modifier TC should be appended to the CPT code.

  Inappropriate usage would be to append TC to global test-only procedures, professional component only procedures, or appending it to a service that both the technical component and professional component were performed by the same provider.

- No modifier for CPT codes eligible for a 26/TC: Global service includes both professional and technical components of the procedure. If a provider needs to identify if a code is eligible for TC/26 modifiers it is best to consult the current National Physician Fee Schedule Relative Value file. If the file does not list separate line items for a CPT code with modifiers 26 and TC, the code should not be billed with those modifiers. If both the professional and technical component of a procedure are provided by the same provider, it should be billed with no modifier.

Providers are encouraged to submit corrected claims if a claim has been submitted with an incorrect modifier.

Definitions

Global Billing: A single comprehensive charge that includes both the technical component and the professional component. For example: If a patient has an X-ray, the procedure code for the x-ray billed with no modifier indicates that the charge is for both the technical and professional components of the procedure. If it is billed without a modifier, it is incorrect to bill the same code again with either a TC or 26 modifier.

Professional Component: The portion of a medical charge that covers costs of a physician's professional services (supervision, interpretation of results, providing a written report). Denoted with modifier 26.

Technical Component: The portion of a service or procedure that involves equipment, supplies, personnel and costs necessary to carry out a service. Denoted with modifier TC.

CMS: Centers for Medicare & Medicaid Services

References

When to Apply Modifiers 26 and TC-AAPC Knowledge Center
Noridian Medicare Jurisdiction F Billing Radiology Services Professional and Technical Components
CMS mln Guidance on Coding and Billing Date of Service on Professional Claims
CMS National Physician Fee Schedule Relative Value File