

Evaluating Professional & Technical Components

By Daniel J. Osborne, M.S.

What specific service did you do to support your billing for the technical component of the test? Do you know how to administer the test? Do you know how much the mobile lab billed for the professional component of the test? These questions, as well as others (**see compliance checklist**), are frequently being asked of providers by investigators evaluating professional and technical component billings.

Today, health care providers face major challenges when determining the appropriateness of their actions, especially as it relates to billing for health care services. Challenges that may become more complex when factoring in the correct billing of services provided by mobile labs (vendors), where a wrong turn or mistake could result in significant and costly problems.

Many providers have executed written agreements for diagnostic tests with vendors for professional services and lease of equipment & technician. The agreements indicate that the tests, or purchased services, will be performed by a leased technician with leased equipment on the provider's patient in the provider's office. When completed, the tests are billed via a professional - technical component split, where the vendor bills only for reading the test results (professional), and the provider, reportedly based on supervising the technician, bills for administering the test (technical).

Some providers following this billing method have found themselves on the wrong side of the law and targets of fraud investigators, despite having been told by a mobile lab it was checked out by an attorney and was legal. So, is it, or is it not, appropriate to separately bill for the professional and technical components of a service or procedure? The simple answer is YES, if you follow the laws & rules, to include:

- **State practice laws:** scope of practice, training/clinical experience requirements, as well as documentation, delegation and supervision standards. *Most states prohibit licensees from performing services they lack training or experience on.*
- **Federal & state laws:** requirements on referrals, remuneration, equipment/space rentals, employee vs. independent contractor, etc. *You must know and comply with these laws. Contact a health care attorney for help!*
- **Current Procedural Terminology (CPT):** codes used by physicians and other practitioners to accurately report their services rendered. *You must ensure the codes reported accurately reflect the service or procedure rendered!*
- **-26 modifier (or 09926):** created by CPT to report only the professional portion of a service. *You must know how to properly use, and recognize that CPT does not specifically address reporting technical components of services.*
- **-TC modifier:** created by Medicare to allow for the separate reporting of the technical component of a service. *Those using this modifier should be familiar with Medicare's rules for use, including physician supervision requirements.*
- **Third-party payers:** specific guides/rules on requirements for reporting technical portions of rendered services. *You must first check with the specific payor to determine their rules for billing technical components!*
- **Relative Value Units (RVU):** recommended charges for services rendered, based on geographic area. *RVU indicates the cumulative charge (combination of technical & professional components) should be equal to that of the global fee.*

Never rely solely upon external vendors or consultants when making major practice decisions, especially those that involve questions as to legalities! These questions are best answered by your attorney, who should be able to provide you with a (legal) opinion that you can bet your practice on!

PUBLISHED: NCMIC Examiner, spring 2002