

Chapter 5

Section 4

Payment For Professional/Technical Components Of Diagnostic Services

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Authority: [32 CFR 199.4\(c\)\(2\)\(ix\)](#) and [\(c\)\(2\)\(x\)](#) and 10 USC 1079(h)(1)

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1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

How are professional and technical components of diagnostic services to be reimbursed?

3.0 POLICY

3.1 Frequently, charges for diagnostic services are split between the professional (physician) and the technical (equipment) components. Wherever possible, separate allowable charges are developed for each component. When a bill is received for the total service, the total allowable charge is to be used in the processing of the claim.

3.2 Under the national allowable charge system, the CHAMPUS Maximum Allowable Charge (CMAC) file provides the contractor with a complete allowable charge or with separate allowable charges for professional and technical components.

3.3 For diagnostic procedures that are still priced using area prevailing allowable charges, the contractor shall establish professional and technical components from the billed charges for the service as identified on the claims.

3.4 Clinical diagnostic lab tests furnished by Critical Access Hospitals (CAHs), are reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

3.5 Effective for services provided on or after January 1, 2017, as required by law, TRICARE adopts Medicare's reduced payments for the technical component (and the technical component of the global fee) of the Physician Fee Schedule (PFS) service for Computed Tomography (CT) services that do not

meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, as required by Section 218(8) of the Protecting Access to Medicare Act (PAMA) of 2014, titled, "Quality Incentives to Promote Patient Safety and Public Health in Computed Tomography (CT) Diagnostic Imaging".

3.5.1 This provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CT service was furnished that was not consistent with the NEMA CT equipment standard.

3.5.2 Claims for the following CT services identified by CPT codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, 75571-75574 that are furnished using equipment that does not meet each of the attributes of the NEMA XR-29-2013 standard, must include modifier **CT**.

3.5.3 A list of CPT codes subject to the **CT** modifier will be maintained in Centers for Medicare and Medicaid Services' (CMS') web supporting files for the annual PFS rule.

3.5.4 Effective January 1, 2017, a payment reduction of 5% applies to the technical component (and the technical component of the global fee) for CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the PFS.

3.5.5 Effective January 1, 2018, and succeeding years, a payment reduction of 15% applies.

3.6 Effective for services provided on or after January 1, 2017, as required by law, TRICARE adopts Medicare's reduced payments for the technical component (and the technical component of the global fee) of the Physician Fee Schedule service for X-ray imaging services provided using film.

Beginning January 1, 2017, claims for X-rays using film must include modifier FX. A payment reduction of 20% applies to the technical component (and the technical component of the global fee) for X-ray services furnished using film as included in Section 502(a)(1) of the Consolidated Appropriations Act of 2016 entitled "Medicare Payment Incentive for Transition from Traditional X-Ray Imaging to Digital Radiography and Other Medicare Imaging Payment Provision".

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