Upcoming Code Edits (Effective July 1, 2019)

**Professional Services Billed on CMS 1500 Form**
When submitting procedures with professional, technical and global components, please use an appropriate modifier. The modifier must be consistent with the place where the service was rendered.

If submitting a diagnostic test or radiology service for a place of service outside your office, then you should:

1. Append modifier 26 to the service specifying that only the professional component was rendered; or
2. Bill only the professional component code when applicable. Do not bill the global or technical component in a place of service other than the office setting. The technical component will be reimbursed to the facility where the patient was seen.

*The only exception is for place of service code 24 (Ambulatory Surgical Center) for pathology services only.*

**NOTE:** If the procedure has been billed as the global or technical component but the technical component has been reimbursed to another provider, then the claim line will be **denied.**