Codify
BY AAPC

Eli's Rehab Report

Reader Question: Append -26 for NCS in Facilities

Question: If our physiatrist performs testing such as nerve conduction studies (NCS) and needle EMGs at a local hospital but provides his own technician, can we report the global code and/or the technical component for these studies, or must we still append modifier -26?

Arizona Subscriber

Answer: If you provide the test in an inpatient diagnostic-related group (DRG) setting, you should append modifier -26 (Professional component) when billing Medicare carriers, regardless of whether the physician employs the technologist. By law, the hospital DRG payment covers the technical component of Medicare services for inpatients. The DRG rules may not apply to certain rehabilitation facilities or skilled-nursing facilities, but they do apply to most hospitals.

Similarly, if the physician's own technician (or the physician himself) performs the test in a facility setting, the physician may claim only the professional component because Medicare rules require that payment for nonphysician services provided to hospital patients be paid only to the hospital. This rule does not apply to other (private or third-party) payers unless they follow the DRG policy.

You may be able to recoup some payment from the facility, however, if the physician provides the equipment and/or technologist or performs the test personally. Although the physician cannot bill the carrier for the technical component under the DRG system, he or she may either bill the facility or establish a separate contract with it to receive the appropriate reimbursement.