Professional/Technical Component Policy FAQ

1. "Review" vs. "Interpretation" is now explicitly defined
UHC draws a hard line between:

- **Radiology review** (looking at images to inform the E/M)
- **Formal written interpretation and report**

Only a **fully written interpretation/report** qualifies the **professional component** for separate reimbursement. Reviews are **always bundled into the E/M**.

2. Applies to BOTH modifier 26 *and* global billing
This is where many providers are still getting tripped up.
If the **same individual provider**:

- Performs the E/M **and**
- Bills a **global radiology code or** a **-26 professional component**

Then:

- The **professional component is bundled into the E/M**
- **Unless a formal radiology report is submitted**

This is not limited to modifier 26 anymore. Global codes are treated the same.

3. Smart Edit behavior matters
UHC confirms a **Smart Edit will fire** when:

- A radiology service (global or -26) is billed
- On the **same date of service**
- By the **same provider** as the E/M
- **Without** an attached interpretation report

The Smart Edit is meant to:

- Prompt for documentation
- Guide report submission

If the report is not provided, the **PC portion will be denied or bundled**, not the entire claim.

4. This is not limited to radiologists
UHC explicitly calls out **non-radiology specialties** (example used: internal medicine).
Any **physician or qualified health care professional** billing imaging + E/M the same day is subject to this rule.

5. Technical component (TC) is unaffected
Only the **professional component** is impacted.

- **TC (equipment, staff, supplies)** remains separately reimbursable
- The policy change does **not** alter TC payment logic

6. Effective dates

- **Commercial / Individual Exchange / MA**: April 1, 2026
- **Rhode Island exception**: June 1, 2026 (per policy summary file)

No retroactivity is stated in the policy materials.

The **office note can be accepted as documentation** if it contains a **full, formal interpretation** of the X-ray or ultrasound. The key distinction UnitedHealthcare makes is **review vs. interpretation**.

What is acceptable:

- The interpretation is clearly documented in the Assessment/Plan or another section of the office note.
- The documentation includes a full written interpretation (findings, impression, and clinical correlation).
- The interpretation is clearly attributable to the billing provider.
- When the interpretation is billed separately (modifier 26 or global code on the same date of service as an E/M), the **office note must be submitted/attached** as the interpretation report.

What is not sufficient:

- A brief statement such as "X-ray reviewed" or "ultrasound reviewed and discussed with patient."
- Documentation that reflects a review only, without a formal interpretation.

Per UnitedHealthcare's **Professional/Technical Component Policy**, when a provider performs only a review (and not a full written interpretation and report), the professional component is considered **included in the E/M service** and is not separately reimbursable. If a full interpretation is performed, documentation must be available to support separate reimbursement.

Important reminder:
If an E/M and a radiology service (modifier 26 or global code) are billed on the same date of service by the same provider, the interpretation documentation must be submitted. If it is not, the professional component may bundle into the E/M or deny. A Smart Edit may trigger requesting that documentation.

To submit the document, you can use either the clearing house or the UHC portal.