

<b>Policy</b>	<b>REIMB-016</b>
<b>Effective Date</b>	<b>09/01/2024</b>
Reviewed/Revised Date	07/17/2024
Next Review Date	07/17/2026
Origination Date	0/01/2024
Originated Department	Medical Management

### Modifier -90 Reference Laboratory

<b>Audience</b>
Medical Management, Claims

<b>Purpose</b>
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

<b>Definition</b>
<p>CPT modifiers (also referred to as Level I modifiers) are used to supplement information or adjust care descriptions to provide extra details concerning a procedure or service provided by a physician. Code modifiers help further describe a procedure code without changing its definition. When laboratory procedures are performed by a third party, other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number. This is an indication of pass-through billing. All entities billing for laboratory services should append identifying modifiers (e.g., 90), when appropriate, in accordance with correct coding.</p>

## Policy/Procedure

**Mountain Health Co-Op will NOT reimburse laboratory tests billed by a party other than the performing laboratory (POS 81) nor tests submitted with modifier 90 appended to the laboratory test procedure code.**

**Mountain Health Co-Op does NOT permit pass-through billing, so balance billing of such services to our members is not allowed.**

### Clinical Rationale

Modifier 90 indicates that a laboratory test was performed by a party other than the treating or reporting physician or other qualified health care professional. The provider who performed the laboratory test must submit laboratory services directly to the Plan. The Plan will not reimburse laboratory tests billed by a party other than the performing laboratory nor tests submitted with modifier 90 appended to the laboratory test procedure code. Reimbursement will be made directly to the laboratory that performed the service(s) for those laboratory services covered by the member's benefits.

### Applicable Coding

#### **Modifier**

**Modifier -90** Reference (Outside) Laboratory

## References

1. American Medical Association (AMA), Current Procedural Terminology (CPT®) and associated publications and services. 2024
2. Centers for Medicare and Medicaid Services (CMS). "Place of Service Code Set-Place of Service Codes for Professional Claims". [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set)
3. MLN006270 CLIA Program and Medicare Lab Services (May 2023) [www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/cliabrochure.pdf](http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/cliabrochure.pdf)
4. Centers for Medicare and Medicaid Services (CMS). Regulations and Guidance; Guidance; Manuals. "Medicare Claims Processing Manual Chapter 16 - Laboratory Services". <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>
5. Clinical Laboratory Improvement Amendments (CLIA) <https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments>
6. CMS Healthcare Common Procedure Coding System (HCPCS) code set. 2024
7. Optum360'. EncoderPro.com for Payers Professional. "Modifier 90".

## Vendors

- Health Plan Services (HPS)

## Review/Revision/Approval History

Date	Description
07/01/2024	New Policy

## Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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