



Manual: Reimbursement Policy

Policy Title: Reference (Outside) Laboratory -- Modifier 90

Section: Modifiers

Subsection: None

Date of Origin: 1/1/2000

Policy Number: RPM045

Last Updated: 2/4/2021

Last Reviewed: 2/10/2021

---

### Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### Reimbursement Guidelines

Moda Health requests claims for laboratory tests and services to be submitted by the laboratory performing the services.

Moda Health strongly discourages providers from submitting claims for lab tests sent to an outside reference laboratory by using modifier 90.

When outside reference laboratory services are billed using modifier 90:

- Modifier 90 (reference laboratory) will not bypass clinical edits, subsets, bundling, etc.
- If some of the blood and/or serum lab procedures are performed by the provider and others are sent to an outside lab and billed with modifier 90, CPT 36415 is not eligible for separate reimbursement.
- CPT codes 99000 and 99001 (handling fees) are not eligible for separate reimbursement.

Note:

Modifier 90 is not considered valid for procedure codes describing venipuncture or other methods of obtaining blood samples or specimens. Use of modifier 90 with these procedure codes (for example 36415-90) will be denied to provider write-off for invalid modifier combination. A drawing fee or venipuncture cannot be referenced out to another lab so modifier 90 should not be reported with CPT code 36415.

## Codes and Definitions

Code	Code Description
Modifier 90	<b>Reference (Outside) Laboratory:</b> When laboratory procedures are performed by a 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.

### Coding Guidelines

“[Modifier 90] is used by a physician or clinic when the laboratory tests performed for a patient are performed by an outside or **reference laboratory**. This modifier is used to indicate that although the physician is reporting the performance of a laboratory test, the actual testing component was a service from a laboratory.” (AMA<sup>1</sup>)

“Modifier -90 is used when laboratory procedures are performed by a party other than the treating or reporting physician and the laboratory bills the physician for the service. For example, the physician (in his office) orders a CBC, the physician draws the blood and sends the specimen to an outside laboratory. The laboratory performs an automated hemogram with a manual differential WBC count and bills the *physician* for the service. The physician would report, routine venipuncture for collection of specimen, code 36415, and the lab procedure CBC, code 85022-90.” (AMA<sup>2</sup>)

### Cross References

- A. “Routine Venipuncture.” Moda Health Reimbursement Policy Manual, RPM012.
- B. “Valid Modifier to Procedure Code Combinations.” Moda Health Reimbursement Policy Manual, RPM019.

### References & Resources

1. American Medical Association. “Modifiers, Modifiers, Modifiers: A Comprehensive Review.” *CPT Assistant*. May 1997: 1-3.
2. American Medical Association. “Modifiers.” *CPT Assistant*. Spring 1991: 7.

### Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

## **IMPORTANT STATEMENT**

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

\*\*\*\*\* The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to [https://www.modahealth.com/medical/policies\\_reimburse.shtml](https://www.modahealth.com/medical/policies_reimburse.shtml) \*\*\*\*\*