Reimbursement Policy

Subject: **Modifier 90**	
Policy Number: **G-20001**	Policy Section: **Coding**
Last Approval Date: **07/07/2023**	Effective Date: **07/07/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providerpublic.empireblue.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Empire BlueCross BlueShield HealthPlus (Empire) covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Empire may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Empire strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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Policy

Empire does not allow pass-through billing for laboratory services. Claims appended with Modifier 90 in an office place of service (11) will be denied unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement will be made directly to the provider who performed the clinical diagnostic laboratory test based on 100% of the applicable fee schedule or contracted/negotiated rate.

Note: This policy does not apply to claims submitted from laboratory and pathology providers allowed to bill in place of service (11).

Related Coding
Standard correct coding applies

Policy History	
07/07/2023	Review approved and effective: removed Reference (Outside) Laboratory and Pass-Through Billing from policy title
11/30/2021	Review approved: policy language (clarification) and definition updated
11/25/2020	Initial approval 11/25/2020 and effective 10/01/2021

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023
- State contract
- State Medicaid

Definitions	
Modifier 90	When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified healthcare professional, the procedure may be identified by adding modifier 90 to the usual procedure number.
Pass-Through Billing	When a provider, such as a physician or hospital, pays a laboratory to perform their tests and then files the claims as though they had performed the tests themselves.
General Reimbursement Policy Definitions	

Related Policies and Materials
Modifier Usage