PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051731

Title	**Modifier 90-Reference (Outside) Laboratory**		
Number	**CP.PP.227.v3.2**		
Last Approval Date	06/11/24	**Original Effective Date**	10/01/04
Cross Reference	N/A		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 90 that are submitted on a CMS 1500 paper professional claim or 837P electronic professional claim form or that are submitted on a UB-04/CMS-1450 paper facility claim or an 837I electronic facility claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	Use of modifier 90 indicates that a third-party clinical reference laboratory performed a laboratory test analysis **rather than** the ordering provider. The Plan does not reimburse laboratory tests appended with modifier 90 that are billed by a party other than the independent reference laboratory that analyzed the lab test when billed on a professional claim or on a facility claim. Only one laboratory may bill for a referred laboratory service. The Plan will reimburse laboratory tests covered by the member's benefits when they are performed by and billed by a reference laboratory participating with the plan. Non-participating laboratories claim submissions will result in increased member financial liability for services not ordered by a treating provider. The independent reference laboratory that analyzed the laboratory test must bill the Plan directly and append modifier 90 for lab tests analyzed to identify referred laboratory services. Modifier 90 is not valid on drawing fee procedure codes.

Codes and Coding Guidelines	The following code(s) are considered drawing fee procedure codes: • 36415 - Collection of venous blood by venipuncture
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	Exceptions to the policy may be made where a provider contract dictates otherwise
Laws, Regulations & Standards	None
References	• Premera Blue Cross Laboratory provider contracts • American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • Center for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, 100-04, Chapter 16-Laboratory Services, Section 40.1.1 • CMS Healthcare Common Procedure Coding System (HCPCS) code set • Clinical Laboratory Improvement Amendments (CLIA) program billing guidelines

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	06/11/24; 08/02/23; 10/13/22; 11/01/21; 11/04/20; 09/08/20; 04/01/20; 05/03/19; 05/28/18; 02/06/18; 03/13/17; 03/14/16; 03/15/15; 03/16/14; 12/15/13; 01/26/12; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 08/29/05; 10/21/04	
Version History	02/06/18	Annual review; no changes
	05/28/18	• Revised Policy statement to indicate lab services must be billed by the provider who performed/analyzed the test; • Revised Exceptions to clarify that the listed exceptions are unique to Alaska providers only
	05/03/19	Annual Review; no changes
	04/01/20	Revised the "Exceptions" section to be more related to contract exception language
	09/08/20	• Expanded the Purpose statement to include a reference to professional and facility claims. • Revised the Policy statement to include facility claims that bill modifier 90 subject to the policy starting with facility claims with dates of service January 13, 2021, and after will no longer be reimbursed
	11/04/20	Expansion of the policy to apply to facility claims with dates of service January 13, 2021, and after will not be implemented.
	11/01/21	Annual review; no changes

	10/13/22	Clarified the Policy statement to make clearer.
	08/02/23	• Expanded the Purpose statement to include Facility claims • Revised the Policy to clarify the correct use of Modifier 90 • Revised the Policy to include Facility claims subject to the policy effective with claim dates of service on and after **December 11, 2023.**
	06/11/24	• Added statement to the policy indicating only one laboratory may bill for a referred laboratory service. • Created new section "Codes and Coding Guidelines" with drawing fee procedure code(s).

This policy was published on June 19, 2024