Reimbursement Policy

Appropriate Use of Modifier -90 and Pass-Through Billing Practices

REIMBURSEMENT POLICY NUMBER: 13

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INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☒ Independent Laboratories

☒ Hospitals

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

Notes: This policy does **not** apply to the following situations:

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

- "Incident-to" claims.
- Reference laboratory arrangements between independent laboratories.
- Reference laboratory arrangements between independent laboratories and hospital laboratories.
- Physician interpretation of diagnostic laboratory tests (these should **not** be reported with modifier -90, but would be reported with modifier -26).

General Plan Position

I. The Company does not allow pass-through billing for laboratory tests. Claims for laboratory tests are to be submitted by the **performing provider** of the service. Claims identified as pass-through billing may be denied reimbursement.

***NOTE**: Denied laboratory services may be resubmitted to the plan **by the performing laboratory** for consideration of reimbursement and coverage. Reimbursement may be made directly to the performing laboratory based on either the Centers for Medicare and Medicaid Services (CMS) fee schedule or negotiated contract rate, whichever is applicable.*

Modifier -90

II. Since only laboratories are able to refer laboratory services, Modifier -90 is considered **not appropriate** for ***non**-laboratory* POS (e.g., physicians may not submit claims on behalf of laboratories for tests referred to these laboratories). Claims submitted with modifier -90 may be denied for inappropriate places of service (e.g., 11, 12, etc.). However, the performing laboratory is allowed to resubmit claims to the Plan directly with the appropriate POS indicator. *(Exceptions: Clinic-based laboratories may be allowed with POS 11. These are still considered laboratories, and they may have the occasional need to refer services to an outside laboratory for tests not offered by their own lab.)*

III. Modifier -90 is considered **not appropriate** for use on ***non**-laboratory services* and will be denied for incorrect coding if appended to an inappropriate procedure code. Examples include, but are not limited to, the following:

A. Specimen drawing services (CPT 36415).
B. Evaluation and management services (E&M codes)
C. Durable medical equipment and supply codes
D. Psychiatric evaluations or psychotherapy services
E. Specimen handling services

Duplicate Payments

IV. Laboratory claims will be denied when the claim has already been paid and a second claim for the same procedure by the same or different provider on the same date of service is received. If two claims are received from both the **referring** (billing) laboratory and the **referred** (performing) laboratory and payment is in dispute, the issue will be resolved in favor of – and reimbursement will be made to – the laboratory who performed the test.

POLICY GUIDELINES

DEFINITIONS

Modifier -90. This modifier is appended to laboratory procedure codes to indicate the service was performed by a reference (or outside) laboratory, rather than the entity submitting the claim.

Pass-through billing. Pass-through billing describes an arrangement between a provider and a laboratory, where the provider pays the laboratory to perform a lab test, and then submits claims for those laboratory services to obtain reimbursement for them.

Place of Service (POS). POS codes should be used on claims to specify the location where service(s) were rendered.[1]

Referring laboratory. A Medicare-approved laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.[2]

Reference laboratory. A Medicare-enrolled laboratory that receives a specimen from another, referring laboratory for testing and that actually performs the test.[2]

Billing laboratory. The laboratory that submits a bill or claim to Medicare.[2]

BACKGROUND

Pass Through Billing

The purpose of this policy is to describe situations where the use of modifier 90 may be inappropriate (or incorrect), as well as provide guidelines regarding the reimbursement of claims submitted using pass-through billing practices.

"Pass through billing" is a practice that occurs when a provider submits a claim for a service that was performed neither by them, nor by any individual under that provider's direct employment.

> "Pass-through billing schemes occur 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. This activity occurs outside the appropriate practices for reference-laboratory billing between laboratories, and is often done to work around the lack of contractual relationships between a laboratory and payer organizations, to avoid scrutiny of the laboratory in question, or to allow the provider to recoup some of the financial benefits of in-office testing without requiring them to operate a laboratory themselves. This may result in double billing to payer organizations if both the laboratory and the provider submit claims for payment. Pass-through billing can undermine the intent and purpose in point-of-care testing…"[3]

Every health care professional has an important role to play in the health care system; however, the health and safety of members can be compromised through pass-through billing arrangements, particularly if the performing laboratory is not CLIA certified. These practices limit or hinder the Plan's quality audits, since the performing laboratory is not the entity submitting claims, which is how random audit sampling is obtained.

In addition, laboratory tests must be performed and billed by a laboratory who is contracted with the health plan. Contracted physicians and providers are expected to use and direct member care to in-network providers. This is because the use of non-contracting laboratories can subject Plan members to unnecessary costs and financial burden.

Finally, while referred laboratory arrangements may be allowed by independent laboratories and hospital facilities when necessary to obtain test results required for clinical decision-making, the use of these arrangements for profit also unnecessarily increases member financial burden.

According to Plan provider contracts, reimbursement may be made for "covered services **rendered by network providers** to members" and Plan provider contracts also state that any subcontracting arrangements must be approved by the plan. In addition, Plan provider contracts also state that network providers are expected to "provide or arrange for care of Members with Network Practitioners and/or Network Facilities." Therefore, the Company does not allow the practice of pass-through billing, especially when such arrangements were not approved by the Plan in advance, or when such arrangements include non-network (aka, non-contracting or out-of-network) laboratory providers. With limited exceptions (e.g., incident-to billing, reference laboratory arrangements between independent laboratories and hospital laboratories, etc.) claims for laboratory services are expected to be submitted **by the performing laboratory**.

Claims identified for referred laboratory services made by entities ***other than*** independent laboratories may be denied. However, denied services may be resubmitted by the rendering provider for consideration of coverage and reimbursement.

Referred Tests

The following information is from the Noridian website[4]:

> "Sometimes a clinical diagnostic independent lab, place of service (POS) 81, refers a specimen to another lab for testing, where a modifier 90 is appended."

Modifier 90

For claims eligible for the reference (outside) laboratory arrangement described in the *Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, §10.1.5.4.1 - Cases Involving Referral Laboratory Services*, it is important to note that not all services are appropriate for the use of this modifier. This modifier is specific to **laboratory** services.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 10/25/2024, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses referred laboratory services:

- Centers for Medicare and Medicaid Services (CMS). Place of Service Code Set for Professional Claims
- Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §40.1 - Laboratories Billing for Referred Tests
- Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §40.1.1 - Claims Information and Claims Forms and Formats
- Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, §10.1.5.4.1 - Cases Involving Referral Laboratory Services
- Noridian webpage: Modifier 90
- Noridian webpage: Laboratories Billing for Referred Tests

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding reference (outside) laboratory services.

BILLING AND CODING GUIDELINES

REFERRED LABORATORY SERVICES

According to Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §40.1.1:[5]

> "Claims for referred laboratory services may be made only by suppliers having specialty code 69, i.e., independent clinical laboratories. Claims for referred laboratory services made by other entities will be returned as unprocessable.

Hospital laboratories may also submit claims for referred laboratory services when they are unable to process certain diagnostic tests in their own laboratory.

MODIFIER 90

Appropriate and Inappropriate Uses

<u>Appropriate Use</u>

The use of modifier -90 is limited to diagnostic testing services.

<u>Inappropriate Use</u>

While the use of modifier -90 may be appropriate for some laboratory testing, it is not appropriate for **all** types of laboratory testing.[3]

Inappropriate Use

Do not report modifier 90 with anatomic pathology and lab services

Do not append modifier 90 for drawing fee (36415)

Cannot be referenced out to another lab

Therefore, modifier -90 should **not** be used with surgical pathology codes (88300-88309), and it should not be used with specimen drawing services (CPT 36415).[3] *(Note that CPT 36416 is not reimbursable under Coding Policy for Venipuncture (CP18).)*

In addition, by the modifier definition, it should not be used for ***non-laboratory*** services. Modifier -90 should not be used with codes for the following services (this is **not** an all-inclusive list):

- Evaluation and management services (E&M codes)
- Durable medical equipment and supply codes
- Psychiatric evaluations or psychotherapy services
- Specimen handling services (99000, 99010)

Duplicate Billing

From the Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 16 - Laboratory Services, §40.1

> "Only one laboratory may bill for a referred laboratory service. It is the responsibility of the referring laboratory to ensure that the reference laboratory does not bill Medicare for the referred service when the referring laboratory does so (or intends to do so). In the event the reference laboratory bills or intends to bill Medicare, the referring laboratory may not do so."[2]

The Plan does not pay for duplicate test services. Only one laboratory may bill for a diagnostic testing service. In the case of referred laboratory services, it is the responsibility of the referring (billing) laboratory to ensure that the reference (performing) laboratory does not bill for the referred service when the referring laboratory does so (or intends to do so). In the event the reference laboratory bills or intends to bill for the services, then referring laboratory may not do so. If a claim is submitted by both laboratories, the performing laboratory will be granted reimbursement.

CROSS REFERENCES

- Incident-To Services, RP5

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). Place of Service Code Set for Professional Claims. Last Updated: 5/2/2024. https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets. Accessed 10/25/2024.

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3. 2018 Healthcare Fraud Prevention Partnership (HFPP) White Paper. https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf. Accessed 10/25/2024.
4. Noridian *Modifier 90*. Updated: 12/9/2023. https://med.noridianmedicare.com/web/jfb/topics/modifiers/90. Accessed 10/25/2024.
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6. CMS. Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, §10.1.5.4.1 - Cases Involving Referral Laboratory Services. Updated: 10/1/2003. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf. Accessed 10/25/2024.
7. Noridian *Laboratories Billing for Referred Tests*. Updated: 11/2/2022. https://med.noridianmedicare.com/web/jfb/specialties/lab#laboratories-billing-for-referred-tests. Accessed 10/25/2024.
8. Congress.gov website. H.R.3299 – Omnibus Budget Reconciliation Act of 1989. https://www.congress.gov/bill/101st-congress/house-bill/3299. Accessed: 10/25/2024.

POLICY REVISION HISTORY

Date	**Revision Summary**
3/2025	New reimbursement policy