Reimbursement Policy

Subject: Modifier 90: Reference (Outside) Laboratory and Pass-Through Billing

Effective Date:	Committee Approval Obtained:	Section:
10/01/2021	**11/25/20**	**Coding**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.amerigroup.com.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

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

	Reimbursement will be made directly to the laboratory that performed the clinical diagnostic laboratory test based on 100% of the applicable fee schedule or contracted/negotiated rate.
History	• Initial committee approval 11/25/20 and effective 10/01/21
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • American Medical Association, CPT 2020, Professional Edition • CMS • Optum 360 Encoder Pro for Payers Professional
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 • **General Reimbursement Policy Definitions**
Related Policies	• Modifier Usage
Related Materials	• None