	Reimbursement Policy

Subject: Modifier 91: Repeat Clinical Diagnostic Laboratory Test

Effective Date:	Committee Approval Obtained:	Section:
10/01/17	**08/03/18**	**Coding**

***** The most current version of our 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/DC. *****

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 District of Columbia, Inc. 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 District 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 both participating and nonparticipating providers and facilities.

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

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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 strives to minimize these variations.

Amerigroup 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 allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 unless provider, District, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate of the clinical diagnostic laboratory test billed with Modifier 91. Medical documentation may be requested to support the use of Modifier 91. It is inappropriate to use Modifier 91 when only a single test result is required. Failure to

	use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service.
History	• Biennial review approved **08/03/18**: Policy template updated • Initial approval **07/19/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance
Definitions	• **Modifier 91:** used to indicate a clinical diagnostic laboratory test was repeated on the same day for the same member to obtain multiple test results; Modifier 91 may not be used in the following situations: o To repeat a test to confirm initial results o Because there was a problem with the specimen or equipment when performing the initial test o When other code(s) describe a series of test results • **General Reimbursement Policy Definitions**
Related Policies	• Modifier Usage
Related Materials	• None