Reimbursement Policy	
Subject: **Modifier 91**	
Policy Number: **G-06020**	Policy Section: **Coding**
Last Approval Date: **12/27/2022**	Effective Date: **07/01/2017**

**** 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://provider.amerigroup.com/GA**.****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Amerigroup Community Care 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, Amerigroup 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Amerigroup 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.

Policy

Amerigroup allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.
Reimbursement is based on 100% 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.

Related Coding
Standard correct coding applies

Policy History	
12/27/2022	Review approved: removed the definition from the name of policy; policy template updated
08/07/2020	Review approved: updated History, References and Research Materials, and Related Policies sections
08/03/2018	Review approved: Policy template updated
08/01/2016	Review approved 08/01/2016 and effective 07/01/2017: single test result language added; Definition section updated
10/31/2014	Review approved: History and policy template updated
06/21/2010	Review approved: History and Definitions sections updated; policy template updated
11/10/2008	Review approved: History section/policy template updated
05/22/2006	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • Optum EncoderPro 2022 • State Medicaid • State contract

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: • To repeat a test to confirm initial results • Because there was a problem with the specimen or equipment when performing the initial test When other code(s) describe a series of test results

General Reimbursement Policy Definitions

Related Policies and Materials
Duplicate or Subsequent Services on the Same Date of Service
Modifier Usage