New York | Medicaid

Reimbursement Policy
Modifiers 90 and 91: Laboratory Services

Policy Number: **G-20001**
Policy Section: **Coding**
Last Approval Date: **07/22/2026**
Effective Date: **12/01/2026**

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://anthembluecross.com/ny/provider**.

Policy

The health plan will consider modifiers 90 and 91 for reimbursement when appended to services billed on professional and outpatient facility claims, in accordance with the guidelines outlined in this policy, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Modifier 90 — Reference (Outside) Laboratory
The health plan does not allow pass-through billing for laboratory services on professional and outpatient facility claims. Laboratory services must be billed by the provider or outpatient facility that performed the test. Claims appended with modifier 90 will not be eligible for reimbursement.

Reimbursement will be made directly to the provider that performed the clinical diagnostic laboratory test based on 100% of the applicable fee schedule or contracted/negotiated rate.

Note: This policy does not apply to pathology services reported with modifier 90 when billed by pathology providers.

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit nystateofhealth.ny.gov or call 855-355-5777.
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Modifiers 91 — Repeat Clinical Diagnostic Laboratory Test

The health plan allows reimbursement of repeat clinical diagnostic laboratory tests appended with modifier 91.

Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate of the repeat clinical diagnostic laboratory tests appended with modifier 91.

Medical documentation may be requested to support appropriate use of modifier 91. Modifier 91 is inappropriate 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

- Modifier 90 Reference (Outside) Laboratory - When laboratory procedures (services) are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number. Not eligible for reimbursement when reported by a physician or other qualified healthcare providers who did not perform the test.
- Modifier 91 Repeat Clinical Diagnostic Laboratory Test - In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient. Eligible for separate reimbursement for repeat clinical diagnostic laboratory tests, except when the procedure code is billed with multiple units and only one unit is permitted. Reimbursement will be based on a single unit.

Definitions

- **Pass-Through Billing** 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.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Duplicate or Subsequent Services in the Same Date of Service
- Modifier Usage

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Policy History

- **07/22/2026 -** Review approved 07/22/2026 and effective 12/01/2026: retired Modifier 91 (G-06020) and combined it into a blended policy titled Modifiers 90 and 91: Laboratory Services (G-20001)
- **07/21/2025 -** Review approved and effective: no changes
- **07/07/2023 -** Review approved and effective: removed Reference (Outside) Laboratory and Pass-Through Billing from policy title
- **11/30/2021 -** Review approved and effective: added Note: to policy language and updated definitions
- **11/25/2020 -** Initial approval 11/25/2020 and effective 10/01/2021

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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, we 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. We strive 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.

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