

Reimbursement Policy

Modifier 90

Policy Number: **G-20001**
Policy Section: **Coding**
Last Approval Date: **7/21/2025**
Effective Date: **7/21/2025**

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://providers.anthem.com/ca>.

Policy

The health plan does not allow pass-through billing for laboratory services. Claims appended with modifier 90 in an office place of service (11) will not be eligible for reimbursement unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement will be made directly to the provider who 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 claims submitted from laboratory and pathology providers allowed to bill in an office place of service (11).

Related Coding

Standard correct coding applies.

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.

- **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

- Modifier Usage

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2025
- State contract
- State Medicaid

Policy History

- 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: Policy language (clarification) and definition updated
- **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.

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.