Wellpoint

Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Modifiers 90, 91, and 92: Laboratory Services – Professional and Facility**	
Policy Number: **C-26002**	Policy Section: **Coding**
Last Approval Date: **06/24/2026**	Effective Date: **11/01/2026**

Policy

The health plan will consider modifiers 90, 91, and 92 for reimbursement when appended to services billed on a professional and outpatient facility claims, in accordance with the guidelines outlined in this policy, unless provider, state, federal 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.

Modifiers 91 - Repeat Clinical Diagnostic Laboratory Test

The health plan allows separate reimbursement for repeat clinical diagnostic laboratory tests appended with modifier 91 on professional claims.

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.

Modifier 92 - Alternative Laboratory Platform Testing

The health plan allows reimbursement for alternative laboratory testing on professional claims when Modifier 92 is appended to the following laboratory codes:

- 86701
- 86702
- 86703
- 87389
- G0432
- G0433

All other laboratory codes billed with modifier 92 are not eligible for reimbursement.

Related Coding

Modifier	Description	Comment
90 - Reference (Outside) Laboratory	When laboratory procedures 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.
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 (eg, 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.
92 - Alternative Laboratory Platform Testing	When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.	Eligible for reimbursement when appended to qualified laboratory codes 86701, 86702, 86703, 87389, G0432, and G0433; all other laboratory codes appended with modifier 92 will deny

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

Laboratory and Venipuncture - Professional and Facility
Modifier Usage - Facility
Modifier Usage - Professional

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum Encoder Pro 2026

Policy History

06/24/2026	Initial approval 06/24/2026 and effective 11/01/2026]; removed modifiers 90, 91, and 92 from Laboratory and Venipuncture Services policy (C-21010) and created a new policy titled Modifiers 90, 91, and 92: Laboratory Services – Professional and Facility (C-26002)

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 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, 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.

Use of Reimbursement Policy
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.