

		Reimbursement Policy
Subject: Modifier 91: Repeat Clinical Diagnostic Laboratory Test		
Effective Date: 07/01/17	Committee Approval Obtained: 08/03/18	Section: Coding
<p>*****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://medproviders.anthem.com/wi.*****</p> <p>These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield (Anthem) if the service is covered by a BadgerCare Plus 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 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.</p> <p>If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:</p> <ul style="list-style-type: none"> • Reject or deny the claim. • Recover and/or recoup claim payment. <p>Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Anthem strives to minimize these variations.</p> <p>Anthem 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.</p>		
Policy	<p>Anthem 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.</p> <p>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</p>	

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	appropriately may result in denial of the repeated laboratory test as a duplicate service.
History	<ul style="list-style-type: none"> • Biennial review approved 08/03/18: Policy template updated • Initial approval 08/01/16 and effective 07/01/17
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • State contracts
Definitions	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> • Modifier Usage
Related Materials	<ul style="list-style-type: none"> • None