Codify
BY AAPC

Modifier Coding Alert

Reader Questions: Follow the Restrictions on Modifier 90 with Referred Lab Claims

Question: My physician ordered a carcinoembryonic antigen (CEA) and hemoglobin test from our lab. Because our lab only performs those tests within the hematology LC level that includes the hemoglobin test, our lab referred the test to an outside lab. How do I code this on a claim?

Arkansas Subscriber

Answer:

You will need to append modifier 90 (Reference [outside] laboratory) on the lab test and become familiar with Medicare's modifier 90 restrictions. The restrictions apply to tests paid on the clinical laboratory fee schedule (CLFS).

You can submit a claim for lab services that your lab did not perform only if your lab is independent and your situation meets one of the following criteria:

- Your lab is located in a rural hospital
- Your facility has an ownership relationship with the reference lab (wholly owned by a separate entity, or one lab wholly owns the other)
- Your lab refers fewer than 30 percent of clinical lab tests out to a reference lab in a year.

Therefore, you cannot bill for tests that non-independent physician labs send to a reference lab.

If you have an independent lab that meets one of the above criteria and you report referred tests, you have to append modifier 90 to the claim.

When you use modifier 90, you need to include the name, address, and clinical laboratory improvement amendments (CLIA) number of both your lab and the reference lab on the claim. CMS also states: "When the reference laboratory is not located in the same billing jurisdiction as the referring laboratory, the referring (billing) laboratory shall use their own NPI for reporting purposes."

Note: You have to file separate claims when submitting paper claims for self-performed and referred tests.

Reference: Refer to www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3014CP.pdf to see CMS Medical Claims Processing Transmittal 3014.