LifeWise Assurance Company

Payment Policy

cmi_051732

Title	**Modifier 91 – Repeat Clinical Diagnostic Laboratory Test**		
Number	**CP.PP.218.v2.7**		
Last Approval Date	09/04/24	**Original Effective Date**	10/01/04
Replaces	N/A		
Cross Reference	*Modifier 76-Repeat Procedure by the Same Provider*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with modifier 91 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	The Plan recognizes modifier 91 appended to a service to indicate a clinical diagnostic laboratory procedure or test was performed **multiple times on the same day/date of service for the same patient in order to obtain new test data over the course of treatment**. Modifier 91 should not be appended to a laboratory procedure or test given for the sole purpose of confirming initial results or because there were testing problems with the specimen or equipment while performing the initial test(s). In addition, modifier 91 should not be used on the repeat laboratory procedure if another procedure code better describes the tests performed. Modifier 91 should also not be appended to a code if the code description clearly calls out multiple or several tests are to be performed such as but not limited to glucose tolerance tests (code 82951) or evocative suppression testing (codes 80400-80439).
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT); Professional Edition • The Centers for Medicare and Medicaid Services (CMS)

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	09/04/24; 12/13/23; 01/17/23; 02/10/22; 02/25/21; 03/05/20; 04/08/19; 04/19/18; 07/18/17; 08/08/16; 08/10/15; 08/10/14; 08/15/13; 08/19/12; 08/29/11; 09/03/10; 11/22/09; 12/19/08; 12/20/07; 11/24/06; 10/17/05; 08/29/05; 10/21/04	
Version History	04/19/18	Clarified the "Policy" statement
	04/08/19	Annual review; no changes
	03/05/20	Added a cross reference to Modifier 76 Payment Policy
	02/25/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms. Added code examples to the "multiple tests" referenced in the last paragraph of the Policy statement.
	02/10/22	Minor clarification added to the end of the first paragraph in the Policy statement
	01/17/23	Annual review; no changes
	12/13/23	Annual review; no changes
	09/04/24	Annual review; no changes