KAISER PERMANENTE®

PAYMENT POLICY

LABORATORY

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington	☒ Kaiser Permanente Health Plan of Washington Options, Inc.	
☒ Commercial	☒ Medicare	☐ Medicaid

Policy

Original Effective Date: 08/30/2022

Claims processed by Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options; Inc. (Kaiser Permanente) will include, but are not limited to, the following criteria when processing laboratory claims.

PROFESSIONAL COMPONENT

A Professional Component will not be reimbursed when a diagnostic laboratory service is provided either manually or with automated equipment, as these codes are not subject to the Professional Component/Technical Component (PC/TC) concept or are Technical Component only codes. Kaiser Permanente follows CMS's PC/TC indicators in determining which services do not qualify for Professional Component reimbursement:

- CMS PC/TC Indicator 3 (Technical Component Only Codes)
- CMS PC/TC Indicator 9 (PC/TC Concept Not Applicable)

For laboratory/pathology claims, the requesting physician must supply the initial diagnosis. For lab services interpreted by a physician/pathologist, the physician/pathologist is responsible for correcting that diagnosis, if necessary, when the final results of the test are available. The final diagnosis should be billed on the claim.

MODIFIER 90

Laboratory claims billed with Modifier 90 will be denied when submitted by a provider other than an independent lab.

Laboratory claims will be denied when the claim has already been paid and a second claim for the same procedure by the same or different provider on the same date of service with or without Modifier 90 is received.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Policy Definitions

Modifier 90 - 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.

Duplicate - A claim an insurance carrier is unable to process due to a claim previously submitted by the same provider for the same service on the same date of service

Place of Service 81 – A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office

Independent Laboratory – An independent laboratory is one that is independent both of an attending or consulting physician's office and of a hospital that meets at least the requirements to qualify as an emergency hospital as defined in §1861(e) of the Social Security Act (See the Medicare Benefits Policy Manual, Chapter 15, for detailed discussion)

Prerequisite(s)

Not Applicable

References

Medicare Claims Processing Manual – Chapter 16 – Laboratory Services – 50.1 Referring Laboratories

CMS Manual System – Pub. 100-4 Medicare Claims Processing

Modifier 90 – Referred Tests

Code Editing payment policy

Frequently Asked Questions

Q1: What place of service (POS) should an independent or reference laboratory report when billing?

A1: When billing, the place of service reported should be the location where the specimen was obtained. For example, a specimen removed from a hospitalized patient and sent to the lab would be reported with POS 21 or 22; a sample taken at a physician's office and referred to the lab would be reported with POS 11; if the independent or reference laboratory did the blood draw in its own setting, it should report POS 81.

Q2: What provider specialty is eligible to report and receive reimbursement for lab services?

A2: You may only bill for lab services that you or your staff perform. If your provider specialty is a reference laboratory, report lab services appended with Modifier 90 to indicate a reference (outside) laboratory.

Q3: Will identical or equivalent lab component codes submitted on the same day for the same patient by the same group physician or other qualified health care professional be denied as duplicate lab services?

A3: Yes, identical, or equivalent lab component codes are denied unless the appropriate repeat lab modifier (Modifier 59, XE, XP, XS, XU, or 91) is appropriately reported with the code(s) submitted.

Q4: Will consecutive or serial tests on the same day to the same patient by either physicians of the same group or multiple providers be denied as a duplicate laboratory service?

A4: Yes, consecutive, or serial tests are denied unless the appropriate repeat laboratory modifier (Modifier 91) is appended to the code.

Q5: If a pathologist and a treating physician report the same codes for the same individual on the same date of service, how will each claim be paid?

A5: Only the pathologist will be paid. The treating physician may also be paid if Modifier 59, XE, XP, XS, XU, or 91 is appropriately reported with the code(s) to distinguish it was a distinct or repeat lab service.

Revision History

04/01/2023 – Added Modifier 90

10/20/2022 – New policy – Created laboratory payment policy to capture all laboratory related policies