Effective 3/20/2026

Lines Of Business: All Lines of Business

Payment Impacting Modifier: Laboratory Services (90, 91)

DISCLAIMER

This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any case. No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, whether electronic, mechanical, photocopying or otherwise, without express written permission from THP. When printed, this version becomes uncontrolled. For the most current information, refer to the following website: healthplan.org.

DEFINITIONS, ACRONYMS, and TERMS

Covered	Medically necessary services, as determined by the plan and described in the

Service	applicable benefit plan, for which a member is eligible for coverage
CPT	Current Procedural Terminology
Fee Schedule	The complete listing of rates for services that represents payment for each unit of service allowed based on applicable coded service identifier(s) for covered services
HCPCS	Healthcare Common Procedure Coding System

BACKGROUND

A modifier is two characters (letters or numbers) appended to a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. The modifier provides additional information about the product or service without changing the meaning of the code billed.

A pricing modifier is a modifier that causes a pricing change for the code billed.

POLICY

Modifier 90	Laboratory procedures performed by healthcare provider other than the treating practitioner
Modifier 91	Repeat clinical laboratory test on the same day for the same patient

Modifier 90 is required when a laboratory procedure is performed by a healthcare provider other than the treating or reporting practitioner or other qualified healthcare professional.

Modifier 91 is required when a clinical diagnostic laboratory test was repeated on the same day for the same patient to obtain multiple test results.

Modifier 91 should **not** be used when tests are rerun to confirm initial results (due to testing problems with specimens or equipment, or any reason when a normal reportable result is all that is required).

Payment Impact

Modifier 90

Line of Business	Percentage (%) of Fee Schedule
Commercial	No Impact
Medicare	No Impact
Mountain Health Trust	No Impact
PEIA	No Impact
Self-Funded/ASO	No Impact

Payment Impact

Modifier 91

Line of Business	Percentage (%) of Fee Schedule
Commercial	50%
Medicare	50%
Mountain Health Trust	50%
PEIA	50%
Self-Funded/ASO	50%

As a reminder, The Health Plan (THP) applies claims edits to all services including those with modifiers