Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-045		
Subject:	Purchased Services		
Effective Date:	December 17, 2018	**End Date:**	
Issue Date:	June 5, 2023	**Revised Date:**	June 2023
Date Reviewed:	March 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☐	**DE**	☒	**NY** ☐
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy prohibits pass-through billing/purchased services. Pass-through billing/purchased services occurs when an ordering practitioner and/or an independent laboratory, requests and bills for services not performed by the ordering physician, practitioner, medical group, or independent laboratory.

The patient's physician may perform the professional component (interpretation), however, that physician may also purchase the technical component from another entity. The provider that performs the professional services, including the professional component (interpretation) of diagnostic tests, must always report them. A provider may not report a professional service that is performed by another entity.

REIMBURSEMENT GUIDELINES:

Providers will not bill, charge, or seek payment for amounts related to the provision of pass-through billing/purchased services from The Plan's members.

Modifier 90: Reference (Outside) Laboratory

Reimbursement for laboratory services ordered by the physician, practitioner, or medical group not performed by the ordering provider are not eligible.

Practitioners should bill only for the component of the laboratory service they perform in their offices and should refer laboratory services that cannot be performed in their office to laboratories that participate with The Plan. Independent laboratories may not bill for services performed by another independent laboratory. Practitioners should not report modifier 90 for services performed by an outside laboratory.

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual

POLICY UPDATE HISTORY INFORMATION:

12 / 2021	Implementation
7 / 2021	Added new policy header with expanded regional checkboxes
6 / 2023	Clarified billing direction for independent laboratories

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HISTORY VERSION

Bulletin Number:	RP-045		
Subject:	Purchased Services		
Effective Date:	December 17, 2018	**End Date:**	
Issue Date:	July 29, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☐	**DE**	☒	**NY** ☐
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
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Only independent labs should use modifier 90 when they send out certain tests to a reference lab. The name, address, and CLIA number of both the referring and reference laboratories must be included on the claim.

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual

POLICY UPDATE HISTORY INFORMATION:

12 / 2021	Implementation
7 / 2021	Added new policy header with expanded regional checkboxes

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Issue Date:	12/17/2018		
Source:	Reimbursement Policy		

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Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

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REFERENCES:

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RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Medical Policy Z-16: Purchased Services- Archived