WPS HEALTH INSURANCE

When processing claims for contracted and noncontracted providers, WPS Health Insurance follows industry standards relating to standard billing modifiers and coding. These guidelines are like those established in UB-04 and CMS' Medicare Database.

Below is a listing of the most commonly billed modifiers with WPS' reimbursement policies. The rates noted apply to our standard business. Self-insured groups retain the right to apply different percentages based on these modifiers. If you have a question on a modifier not listed below, please contact our Customer Service department.

**Term definition**

**Fee Schedule Allowance (allowed amount)** means the maximum rate allowed for the health care services according to the fee schedule.

| Modifier | Description | Adjustment Rate |
|---|---|---|
| Modifier 22 | Increased procedural services | Maximum of 110% of Fee Schedule Allowance/Contracted Rate with supporting documentation |
| Modifier 26 | Professional component | Professional Fee Schedule Allowance/Contracted Rate |
| Modifier 33 | Preventive service | Informational modifier; no additional reimbursement, but used for quality metrics |
| Modifier 50 | Bilateral procedure | 150% of Fee Schedule Allowance/ Contracted Rate; submit one line with one unit |
| Modifier 51 | Multiple procedure | 50% of Fee Schedule Allowance/Contracted Rate for each additional procedure, unless procedure is exempt from multiple procedure logic |
| Modifier 52 | Reduced services | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier 53 | Discontinued procedure | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier 54 | Surgical procedure only | 70% of Fee Schedule Allowance/Contracted Rate |
| Modifier 55 | Follow-up care only | 20% of Fee Schedule Allowance/Contracted Rate |
| Modifier 56 | Preoperative management | 10% of Fee Schedule Allowance/Contracted Rate |
| Modifier 62 | Co-surgeons (two surgeons) | 125% of Fee Schedule Allowance/Contracted Rate divided by 2 for each surgeon (62.5% each) |
| Modifier 78 | Unplanned return to the operating/procedure room by the same physician during the postoperative period | 70% of Fee Schedule Allowance/Contracted Rate |
| Modifier 80 | Assistant surgeon | 20% of Fee Schedule Allowance/Contracted Rate for MD<br>10% of Fee Schedule Allowance/Contracted Rate for PA |
| Modifier AS | Assistant surgeon at surgery | 10% of Fee Schedule Allowance/Contracted Rate for PA |
| Modifier 81 | Minimum assistant surgeon | 20% of Fee Schedule Allowance/Contracted Rate for MD<br>10% of Fee Schedule Allowance/Contracted Rate for PA |
| Modifier 82 | Assistant surgeon w/o resident | 20% of Fee Schedule Allowance/Contracted Rate for MD<br>10% of Fee Schedule Allowance/Contracted Rate for PA |

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|---|---|---|
| Modifier 95 | Telemedicine service via real-time interactive audio and video telecommunications | Informational modifier only; no additional reimbursement |
| Modifier 99 | Used when more than four modifiers are submitted per line | Modifiers billed determine appropriate reimbursement |
| Modifier SG | Surgery center primary | 100% of Fee Schedule Allowance/Contracted Rate |
| Modifier SG-51 | Surgery center secondary | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier TC | Technical | Fee Schedule Allowance/Contracted Rate |
| Modifier 59 | Distinct procedural services | Informational modifier impacts bundling |
| Modifier XE | Separate encounter, distinct service | Informational modifier impacts bundling |
| Modifier XP | Separate practitioner, distinct service | Informational modifier impacts bundling |
| Modifier XS | Separate structure, distinct service | Informational modifier impacts bundling |
| Modifier XU | Unusual non-overlapping distinct service | Informational modifier impacts bundling |
| Anesthesia | All general anesthesia surgical services should be billed with the appropriate CPT code ranges for anesthesia services 00100–01999 to ensure appropriate reimbursement; anesthesia time should be reported in minutes | Qualifying circumstances should be billed with the appropriate CPT code |
| Anesthesia Modifiers | Description | Adjustment Rate |
| Modifier AA | Administered by anesthesiologist | 100% of Fee Schedule Allowance/Contracted Rate |
| Modifier AD | Medical supervision of more than four concurrent anesthesia procedures | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier QK | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier QS | Monitored anesthesia service | 100% of Fee Schedule Allowance/Contracted Rate |
| Modifier QX | Administered by CRNA with medical direction | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier QY | Medical direction of CRNA by anesthesiologist | 50% of Fee Schedule Allowance/Contracted Rate |
| Modifier QZ | Administered by CRNA without medical direction | 100% of Fee Schedule Allowance/Contracted Rate |
| Physical Status Modifiers (Anesthesia) | Description | Adjustment Rate |
| Modifier P1 | A normal, healthy patient | No additional units allowed |
| Modifier P2 | A patient with mild systemic disease | No additional units allowed |
| Modifier P3 | A patient with severe systemic disease | One additional unit |
| Modifier P4 | A patient with severe systemic disease that is a constant threat to life | Two additional units |
| Modifier P5 | A morbid patient who is not expected to survive without the operation | Three additional units |
| Modifier P6 | A declared brain-dead patient whose organs are being removed | No additional units allowed |
| DME | Description | Adjustment Rate |
| NU | Purchased DME | Fee Schedule Allowance/Contracted Rate |
| RR | Rental DME | Fee Schedule Allowance/Contracted Rate |

Always submit the full billed amount. WPS will apply the reimbursement methodology noted above.

Reimbursements based on AWP will utilize the MediSpan data or subsequent replacement of First Data Bank and Redbook sources.

**Multiple endoscopies/colonoscopies**

Reimbursement for multiple endoscopies/colonoscopies will be made by WPS using the following method(s):

Billed charges reimbursement:

- 100% of the contracted fee for the procedure listed with the highest value (primary procedure).
- 10% of the contracted fee for multiple endoscopies/colonoscopies beyond the primary procedure.

Fee Schedule Allowance:

- 100% of the Fee Schedule Allowance for the highest cost endoscopy/colonoscopy CPT (based on the fee schedule, not the billed amount).
- For each less costly endoscopy/colonoscopy CPT, reimbursement will be calculated by taking the Fee Schedule Allowance for each less costly endoscopy/colonoscopy less the Fee Schedule Allowance of the base code for the corresponding endoscopy family.