When processing claims for contracted and non-contracted providers, WPS follows industry standards relating to standard billing modifiers and coding. The guidelines are similar to those established in UB-04 and CMS's Medicare Database.

Below is a listing of the most commonly billed modifiers with WPS's 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

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	Preventative 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 Allowances/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 80	Assistant Surgeon	20% of Fee Schedule Allowance/Contracted Rate for MD 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 10% Fee schedule Allowance/Contracted Rate for PA
Modifier 82	Assistant Surgeon w/o Resident	20% of Fee Schedule Allowance/Contracted Rate for MD 10% of Fee Schedule Allowance/Contracted Rate for PA
Modifier 99	Used when more then 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
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 more then 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

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