



WEA Trust
Claims Processing Guidelines
 April 2010

Customer Service

(800) 279-4000

Non-Summer Hours – M-F: 7:30 a.m. – 5:00 p.m.
 Summer Hours – M-Th: 7:15 a.m. – 5:00 p.m.; Fridays: 7:15 p.m. – 1:00 p.m.
 Voicemail also available

When processing claims for payment, WEA follows industry standards relating to coding and billing procedures and guidelines, such as those established in UB-04 and CMS’s Medicare Database, including the National Correct Coding Initiative (NCCI), Medicare’s rules including but not limited to multiple and bilateral surgical procedures, assistant surgeons, co-surgeons, and quality measures including but not limited to the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

Below is a list of the most commonly billed modifiers and WEA's Reimbursement Policies. Please be advised that this list is not all-inclusive. If you have a question on a reimbursement policy that is not listed below, please contact Customer Service at the number listed above.

Definition of Terms:

1. *Allowed Amount* means the maximum rate Provider is allowed for furnishing a health care service to a Participant. For network providers the Allowed Amount will be the contracted rate as set out in the WEA Provider Agreement. For non-network providers the Allowed Amount will be WEA's Reasonable and Customary Fee.
2. *Reasonable and Customary Fee* means the state average of actual fees charged by physicians and other providers with similar training adjusted by factors to account for geographic, marketplace and other legitimate price differences.

MODIFIER	DESCRIPTION	WEA Reimbursement Policy
Modifier 21	Prolonged E&M service	No additional payment is allowed for service billed with this modifier.
Modifier 24	An unrelated E&M service by the same physician during post-op period	Reimbursement considered independently from services in which they are not a component.
Modifier 32	Mandated services	The member's benefit plan determines if mandated services are covered or excluded.

MODIFIER	DESCRIPTION	WEA Reimbursement Policy
Modifier 50	Bilateral procedure - A procedure carried out on both sides of the body	Procedures should be billed on one line. Reimbursed at 150% of one side for the entire surgery.
Modifier 51	Multiple procedures - Many procedures carried out at the same time	Primary procedure reimbursed at 100% of the Allowed Amount. The remaining procedures that are subject to multiple surgery reductions will be reimbursed at 50% of Allowed Amount.
Modifier 57	Decision for surgery	E&M CPT codes (99201-99499) submitted with Modifier 57 are allowed separate from the reimbursement for the surgical procedure code if the documentation supports that the decision for surgery was made during the global preoperative period. Documentation required upon request.
Modifier 54	Surgical care only	WEA shall apply the appropriate surgical split percentage based upon the RVU value assigned by CMS.
Modifier 55	Post-op management only	WEA shall apply the appropriate surgical split percentage based upon the RVU value assigned by CMS.
Modifier 56	Pre-op management only	WEA shall apply the appropriate surgical split percentage based upon the RVU value assigned by CMS.
Modifier 58	Staged/related procedure/service by the same physician during post-op period	Primary procedure is reimbursed at 100% of the Allowed Amount. Remaining procedures that are subject to multiple surgery reductions will be reimbursed at 50% of Allowed Amount.
Modifier 62	Two surgeons/co-surgeons	Reimbursement for co-surgeons is 125% of the Allowed Amount, divided equally between the two surgeons.
Modifier 78	Return to operating room for related procedure during post-op period	Reimburse at 100% of the Allowed Amount.
Modifier 79	Unrelated procedure/service by same physician during post-op period	Reimbursement for unrelated services will be considered independently from services in which they are not a component.
Modifier 80	Assistant surgeon	MD assistant surgeon reimbursed at 25% of the Allowed amount. Non-MD assistant reimbursed at 15% of the Allowed Amount.
Modifier 81	Minimum assistant surgeon	MD assistant surgeon reimbursed at 25% of the Allowed Amount. Non-MD assistant reimbursed at 15% of the Allowed Amount.

MODIFIER	DESCRIPTION	WEA Reimbursement Policy
Modifier 82	Assistant surgeon when a qualified resident surgeon was unavailable	MD assistant surgeons reimbursed at 25% of the Allowed Amount. Non-MD assistants reimbursed at 15% of the Allowed Amount.
Modifier 90	Reference laboratory	Reimbursement base on provider's agreement with the Trust.
Modifier 99	Multiple modifiers	Services requiring the use of multiple modifiers should be billed with all modifiers listed.
Modifier AA	Anesthesia services personally performed by anesthesiologist.	100% of Allowed Amount
Modifier AD	Medical supervision: more than 4 concurrent anesthesiologists	50% of Allowed Amount. Total reimbursement for will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier AS	Surgical Assist	15% of the Allowed Amount.
Modifier QK	Medical direction of two, three or four concurrent anesthesia	50% of Allowed Amount. Total reimbursement for CRNA and MD will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier QX	CRNA/AA with medical direction by a physician.	50% of Allowed Amount. Total reimbursement for CRNA and MD will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier QY	Medical direction of one CRNA/AA by an anesthesiologist	50% of allowed amount. Total reimbursement for CRNA and MD will not exceed the Allowed Amount otherwise recognized had the service been furnished by the MD alone.
Modifier QZ	CRNA/AA without medical direction by physician	100% of Allowed Amount
Modifier P1	Physical Status – Normal Health Patient	100% of Allowed Amount
Modifier P2	Physical Status – Patient with mild systemic disease	100% of Allowed Amount

MODIFIER	DESCRIPTION	WEA Reimbursement Policy
Modifier P3	Physical Status – Patient with severe systemic disease	100% of Allowed Amount
Modifier P4	Physical Status – Patient with severe systemic disease that is constant threat to life	100% of Allowed Amount
Modifier P5	Physical Status – Moribund patient who is not expected to survive without operation	100% of Allowed Amount
Modifier P6	Physical Status – A declared brain-dead patient whose organs are being removed for donor purposes	100% of Allowed Amount