

To:
 HMOs and Other
 Managed Care
 Programs
 Physicians
 Physician clinics
 Physician
 assistants

Policy changes for anesthesia qualifying circumstances, invasive monitoring, and select vascular procedures

This Update addresses the following changes to Wisconsin Medicaid anesthesia policy:

- Procedure codes no longer reimbursable.
- Current procedure codes and their appropriate type of service (TOS).
- Reimbursable quantities for qualifying circumstances, invasive monitoring, and select vascular procedures.

The purpose of these changes is to make Wisconsin Medicaid anesthesia policy for qualifying circumstances, invasive monitoring, and other vascular procedures more consistent with common coding practices for billing purposes.

This Update applies to fee-for-service Medicaid providers only. If you are a Medicaid HMO network provider, contact your managed care organization for more information about their coverage policies, requirements, and billing procedures.

Qualifying circumstances for anesthesia

Qualifying circumstance procedure codes

Anesthesia services are sometimes provided under difficult circumstances including:

- Extraordinary condition of the patient.
- Special operative conditions.
- Unusual risk factors.

When these circumstances occur, the performing or supervising anesthesiologist may be reimbursed for one or more CPT qualifying circumstance procedure code(s). (This reimbursement is in addition to reimbursement for the CPT code that best describes the surgical, therapeutic, or diagnostic procedure performed.)

Wisconsin Medicaid reimburses the following anesthesia qualifying circumstance procedure codes when billed with TOS “7”:

<u>CODE</u>	<u>DESCRIPTION</u>
99100	Anesthesia for patient of extreme age, under one year and over seventy
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency conditions (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)

Since qualifying circumstance procedure codes 99105 (patient status, risk, physical status) and 99125 (extracorporeal circulation) are no longer listed in CPT, Wisconsin Medicaid no longer reimburses these procedure codes effective for dates of service on or after March 1, 1999.

Qualifying circumstance quantities

More than one qualifying circumstance procedure code may be billed for the same recipient on the same date of service. Always indicate a quantity of “1.00” for each qualifying circumstance procedure code. Do not indicate time units or base units for qualifying circumstance procedure codes.

Invasive monitoring for anesthesia

Invasive monitoring procedure codes

Effective for dates of service on or after October 1, 1999, Wisconsin Medicaid will no longer reimburse local procedure code W0125 (invasive monitoring). Instead, to achieve a greater consistency with CPT coding instructions, Wisconsin Medicaid will reimburse *anesthesiologists* for the following CPT procedure codes when billed with TOS “7”:

<u>CODE</u>	<u>DESCRIPTION</u>
36488	Placement of central venous catheter; percutaneous, age 2 years or under
36489	Placement of central venous catheter; percutaneous, over age 2
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous
93503	Insertion and placement of flow directed catheter (e.g., Swan-Ganz) for monitoring purposes

Other providers (e.g., surgeons) performing these services should use TOS “2” (surgery).

Invasive monitoring quantities

When billing, always indicate a quantity of “1.00” for invasive monitoring procedure codes for each date of service. Do not indicate time units or base units for invasive monitoring procedure codes.

Other vascular procedures for anesthesia

Wisconsin Medicaid reimburses anesthesiologists separately for the following vascular procedures when performed in other than a surgical/anesthesia setting: 36000-36248, 36488-36491, and 36600-36660. Wisconsin Medicaid does not reimburse anesthesiologists for qualifying circumstance procedure codes when the anesthesiologist is billing vascular procedures. Bill these vascular procedures with TOS “2,” not “7.” The quantity billed should indicate the number of times the vascular procedure was performed. Do not indicate time units or base units for vascular procedures.

CPT anesthesia codes not covered

Please note that Wisconsin Medicaid does not reimburse the CPT anesthesia codes (00100-01999) except on Medicare crossover claims. Nor does Wisconsin Medicaid recognize patient status modifiers P1-P6 as described in the anesthesia section of CPT.

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information. Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309. For provider questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our web site at: www.dhfs.state.wi.us/medicaid.