BlueCross BlueShield of Texas

Anesthesia Payment & Billing Information

Time and Points Eligible Anesthesia Procedures Defined

Blue Cross and Blue Shield of Texas (BCBSTX) has determined that only certain anesthesia procedures are subject to be reimbursed on time and points methodology.

When procedures not subject to time and points methodology are submitted using anesthesia indicators for Time & Points such as:

- using an anesthesia modifier, or
- using time on the claim, or
- if submitted on a non-HIPAA claim format, *(Type of Service = 7)*,

The provider may receive a denial message for procedure noting that the service is not eligible for time and points payment methodology.

Anesthesia Services

Services involving administration of anesthesia should be reported by the use of the Current Procedural Terminology (CPT®) anesthesia five-digit procedure codes, American Society of Anesthesiologists (ASA) or CPT surgical codes plus an appropriate modifier. Providers should determine the most appropriate CPT code(s) for surgical procedures and crosswalk the CPT code(s) to the appropriate anesthesia procedure code combination.

An anesthesiologist, Certified Registered Nurse Anesthetist (CRNA) or Anesthesiology Assistant (AA) can provide anesthesia services. The anesthesiologist, CRNA or AA can bill separately for anesthesia services personally performed. When an anesthesiologist provides medical direction to a CRNA or AA, both the anesthesiologist and the CRNA/AA should bill for the appropriate component of the procedure performed as applicable under state and federal law. Each provider should use the appropriate anesthesia modifier.

In keeping with the American Medical Association CPT book, services involving administration of anesthesia include the usual pre-operative and post-operative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry). Intra-arterial, central venous and Swan-Ganz catheter insertion are allowed separately.

Payment Calculation Information	
Time Units	Time units will be determined by using the total time in minutes actually spent performing the procedure. Fifteen minutes is equivalent to one (1) time unit. Time units will be rounded to the tenth. Therefore, if the procedure lasted 49 minutes, the time units in this example would be 3.26 or 3.3 time units. The units field 24G of the CMS-1500 form should reflect the number of minutes the provider spent on the procedure, (e.g. one hour-thirty minutes should be reflected as (90) in the units field). Anesthesia time begins when the provider of services physically starts to prepare the patient for induction of anesthesia in the operating room (or equivalent) and ends when the provider of services is no longer in constant attendance and the patient may safely be placed under postoperative supervision.
Base Points	The basis for determining the base points is the Relative Value Guide published by the American Society of Anesthesiologists (ASA). BCBSTX shall implement any yearly update of the Relative Value Guide within 60 days of receipt. Base points used to process claims will be the base points in effect on the date(s) Covered Services are rendered. The exception to this will be Covered Services provided on dates between the receipt of the Relative Value Guide published by ASA and implementation of the updated material. Claims incurred during the exception period will be priced based on the Relative Value Guide in effect on December 1st of the prior calendar year. Newly established codes will be paid at BCBSTX determined rates until the annual update is implemented.

			Unit Value(s)
Physical Status/ Modifiers/Status Classification – to be billed by Anesthesiologist, CRNA or Anesthesiology Assistant **Refer to ASA Physical Status Classification System for additional information**	P1	A normal healthy person (ASA I)	0
	P2	A patient with mild systemic disease (ASA II)	0
	P3	A patient with severe systemic disease (ASA III)	1
	P4	A patient with severe systemic disease that is a constant threat to life (ASA IV)	2
	P5	A moribund patient who is not expected to survive without the operation (ASA V)	3
	P6	A declared brain dead patient whose organs are being removed for donor purposes (ASA VI)	0

			Unit Value(s)
Qualifying Circumstances – to be billed by anesthesiologists and/or CRNAs	99100	Special Anesthesia Services *(list separately in addition to code for primary procedure) - Special*	1
	99116	Anesthesia for Hypothermia *list separately in addition to code for primary procedure)*	5
	99135	Special Anesthesia Procedure *(list separately in addition to code for primary procedure)*	5
	99140	Emergency Anesthesia (specify) *(list separately in addition to code for primary procedure)*	2

Payment Calculation	**In-Network Professional Providers:** Time units plus base points plus unit value(s) allocated to physical status modifiers and or qualifying circumstances listed above (if applicable) equals total units. Allowable amount equals the anesthesia conversion factor multiplied by the total units. **Out-of-Network Providers:** BCBSTX follows industry standard guidelines and member's benefit coverage.

Modifier Information Billed by an Anesthesiologist	AA	Anesthesia services performed personally by the anesthesiologist
	AD	Medical Supervision by a physician, more than four concurrent anesthesia procedures
	QK	Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals
	QY	Medical Direction of one CRNA or AA by an anesthesiologist

Modifier Information Billed by a CRNA or Anesthesiology Assistant	QX	CRNA or Anesthesiology Assistant service with medically direction by a physician
	QZ	CRNA service without medical direction by a physician

Anesthesia Modifier Reimbursement

Blue Cross and Blue Shield of Texas maximum allowable fees for services billed as MD supervision of a CRNA are as follows:

QY	MD Medical Direction of a CRNA/AA	$325.52
QK	MD Medical Direction of a CRNA/AA	$310.01
AD	MD supervision of a CRNA/AA	$162.76

OB Time and Points Maximum Allowable Points

The following are the current Blue Cross and Blue Shield of Texas total maximum allowable points for Vaginal or Cesarean deliveries:

Obstetrical Vaginal delivery: 23 total maximum allowable points
Obstetrical Cesarean delivery: 32 total maximum allowable points

If general anesthesia is used in the performance of any obstetrical Vaginal or Cesarean delivery, the maximum allowable points are applicable. In the event that total actual points are less than the total maximum allowable points, you will be reimbursed based on total actual points.

Effective July 1, 2014, if Physical Status Modifiers P3, P4 or P5 are billed, the full unit value for these Physical Status Modifiers will be reimbursed even if the obstetrical delivery total maximum allowable points have been met.

Reimbursement of OB Anesthesia Add-On Codes 01968 and 01969

When a primary OB delivery anesthesia procedure (01967) is billed with either 01968 and/or 01969, Blue Cross and Blue Shield of Texas allows a combined maximum of 32 points.

Ventilator Management in Conjunction with Anesthesia Services 94656 and 94657
Ventilation management billed on the same day as an anesthesia procedure is part of the global anesthesia service for the first 24 hours after anesthesia induction and therefore it is not billable. If procedure code 94656 is reported on the same day, on the same patient, by the same provider as an anesthesia procedure, the ventilation management service will be denied. Subsequent ventilation management (94657) billed on the same day as an evaluation and management service is considered part of the evaluation and management service and is not payable separately even if the evaluation and management service is billed with modifier 25. If the patient develops unusual postoperative respiratory problems that require reintubation and/or ventilation management, the physician should report the service with critical care or the appropriate evaluation and management code(s).
Daily Hospital Management of Epidural or Subarachnoid Continuous Drug Administration - 01996
Procedure code 01996 is not allowed on the day of the operative procedure. Only one (1) unit of service *(not base units)* will be allowed each day, starting on the first day following the surgical procedure, up to a maximum of three (3) days.
62310, 62311, 62318 and 62319
BCBSTX has determined that these procedures are surgical services and claims should reflect a type of service of 2. These codes will be reimbursed at the current maximum allowable as determined by BCBSTX Claims filed with CPT anesthesia procedure code 01991 or 01992 and type of service of 7 will be reimbursed on time and points methodology.

***Note**: The codes referenced in the information above are subject to changes made by the owner of the code set (i.e., CPT, HCPCS, Revenue Codes, etc.).*