



Anesthesia Payment & Billing Information

Time and Points Eligible Anesthesia Procedures Defined

HMO Blue[®] Texas and Blue Cross and Blue Shield of Texas have determined that certain anesthesia procedures will be reimbursed on time and points methodology.

Procedures that are ***not*** included on the [Anesthesia Time & Points Eligible List](#) will not be reimbursed using time and points methodology. If a procedure is ***not*** on this list, and it is 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*),

then the provider may receive a denial message for that 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 a modifier. HMO Blue Texas and Blue Cross and Blue Shield of Texas will require that the appropriate anesthesia modifier be filed on anesthesia services.

An anesthesiologist or a CRNA can provide anesthesia services. The anesthesiologist and the CRNA can bill separately for anesthesia services personally performed. When an anesthesiologist provides medical direction to a CRNA, both the anesthesiologist and the CRNA should bill for the appropriate component of the procedure performed. Each provider should use the appropriate anesthesia modifier.

In keeping with the American Medical Association Current Procedural Terminology (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	<p>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).</p> <p>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.</p>
Base Points	<p>The basis for determining the base points is the Relative Value Guide published by the American Society of Anesthesiologists (ASA). HMO Blue Texas and Blue Cross and Blue Shield of Texas 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 HMO Blue Texas and Blue Cross and Blue Shield of Texas determined rates until the annual update is implemented.</p>



			Unit Value(s)
Physical Status Modifiers – to be billed by anesthesiologists and/or CRNAs	P1	A normal healthy person	0
	P2	A patient with mild systemic disease	0
	P3	A patient with severe systemic disease	1
	P4	A patient with severe systemic disease that is a constant threat to life	2
	P5	A moribund patient who is not expected to survive without the operation	3
	P6	A declared brain dead patient whose organs are being removed for donor purposes	0
			Unit Value(s)
Qualifying Circumstances – to be billed by anesthesiologists and/or CRNAs	99100	Anesthesia for patients of extreme age, under 1 year and over 70 <i>(list separately in addition to code for primary procedure)</i>	1
	99116	Anesthesia complicated by utilization of total body hypothermia <i>(list separately in addition to code for primary procedure)</i>	5
	99135	Anesthesia complicated by utilization of controlled hypotension <i>(list separately in addition to code for primary procedure)</i>	5
	99140	Anesthesia complicated by emergency conditions (specify) <i>(list separately in addition to code for primary procedure)</i>	2
Payment Calculation	Time units plus base points plus unit value(s) allocated to physical status modifiers and/or qualifying circumstances listed above (if applicable) equals "Y". Allowable amount equals the anesthesia conversion factor multiplied by "Y".		



Anesthesia Modifier Reimbursement						
Modifier Information Billed by an Anesthesiologist	AA	Anesthesia services personally performed by the anesthesiologist				
	AD	Supervision, more than four procedures				
	QK	Medical Direction of two, three or four concurrent anesthesia procedures				
	QY	Medical Direction of one CRNA by an anesthesiologist				
Modifier Information Billed by a CRNA	QX	Anesthesia, CRNA medically directed				
	QZ	Anesthesia, CRNA not medically directed				
Anesthesia Modifier Reimbursement						
Effective for dates of service on or after May 19, 2004, the HMO Blue Texas and 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	\$325.52				
QK	MD Medical Direction of a CRNA	\$310.01				
AD	MD supervision of a CRNA	\$162.76				
OB Time and Points Maximum Allowable Points						
The following are the current HMO Blue Texas and Blue Cross and Blue Shield of Texas total maximum allowable points for Vaginal or Cesarean deliveries:						
<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 20px;">Obstetrical Vaginal delivery:</td> <td>23 total maximum allowable points</td> </tr> <tr> <td>Obstetrical Cesarean delivery:</td> <td>32 total maximum allowable points</td> </tr> </table>			Obstetrical Vaginal delivery:	23 total maximum allowable points	Obstetrical Cesarean delivery:	32 total maximum allowable points
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.						
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, HMO Blue Texas and 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

HMO Blue Texas and Blue Cross and Blue Shield of Texas have 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 HMO Blue Texas and Blue Cross and Blue Shield of Texas. 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).*

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