

# Changes Announced in

# anesthesia

## Fee Maximum



Blue Cross and Blue Shield of Texas will implement a change in the maximum allowable fee schedules utilized for its participating HMO Blue® Texas, PPO and ParPlan provider networks for certain anesthesia procedures. Please refer to the payment and billing guidelines below and our Web site ([www.bcbstx.com](http://www.bcbstx.com)) for additional information detailing these changes.

If you are participating in any of the above products through a Medical Group or Independent Practice Association (IPA) agreement, please contact that organization for additional information.

We appreciate your continued support and participation in HMO Blue Texas and Blue Cross and Blue Shield of Texas. If you have any questions, please contact your Provider Representative.

Following below are additional payment and billing guidelines for anesthesiologists and CRNAs:

### **TIME AND POINTS PAYMENT METHODOLOGY: ELIGIBLE ANESTHESIA PROCEDURES DEFINED**

Blue Cross and Blue Shield of Texas and HMO Blue Texas have determined that certain anesthesia procedures will be reimbursed on time and points methodology. A listing of anesthesia procedures eligible for time and points payment methodology (effective July 28, 2004) is available on our website at [www.bcbstx.com](http://www.bcbstx.com). Blue Cross and Blue Shield of Texas and HMO Blue Texas shall implement any yearly update of the list within 60 days of our receipt of the update.

Effective July 28, 2004, procedures that are not included on this 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 and points such as:

- using an anesthesia modifier (see list in table following in article entitled “Anesthesia Services”), 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 or CPT surgical codes plus a modifier. Effective on or after July 28, 2004 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 2004 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.

### Modifiers to be billed by the Anesthesiologist

- AA Anesthesia services personally performed by the anesthesiologist
- QY Medical direction of one CRNA by an anesthesiologist
- QK Medical direction of two, three or four concurrent anesthesia procedures
- AD Supervision, more than four procedures

### Modifiers to be billed by a CRNA only

- QX Anesthesia, CRNA medically directed
- QZ Anesthesia, CRNA not medically directed

### Physical Status Modifiers

*(to be billed by Anesthesiologists and CRNAs)*

- P1 A normal healthy person
- P2 A patient with mild systemic disease
- P3 A patient with severe systemic disease
- P4 A patient with severe systemic disease that is a constant threat to life
- P5 A moribund patient who is not expected to survive without the operation
- P6 A declared brain dead patient whose organs are being removed for donor purposes

### Qualifying Circumstances

*(to be billed by Anesthesiologists and CRNAs with units of one [1] only)*

- 99100 Anesthesia for patients of extreme age, under 1 year and over 70 (list separately in addition to code for primary procedure)
- 99116 Anesthesia complicated by utilization of total body hypothermia (list separately in addition to code for primary procedure)
- 99135 Anesthesia complicated by utilization of controlled hypotension (list separately in addition to code for primary procedure)
- 99140 Anesthesia complicated by emergency conditions (specify) (list separately in addition to code for primary procedure)

When filing paper claims where Type of Service (TOS) values are included, Blue Cross and Blue Shield of Texas 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 Blue Cross and Blue Shield of Texas and HMO Blue 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.

Providers that are sending claims electronically (in the HIPAA format) need to be aware that this article does not apply to them since the TOS value is not available on the HIPAA claim format.

**REMINDER:** Effective for dates-of-service on or after May 19, 2004, HMO Blue® Texas/Blue Cross and Blue Shield of Texas implemented a change in the maximum allowable fee for services billed as MD supervision of a CRNA. The HMO Blue Texas/Blue Cross and Blue Shield of Texas maximum allowable fees are as follows:

MD supervision of a CRNA billed with modifier QY = \$325.52

MD supervision of a CRNA billed with modifier QK = \$310.01

MD supervision of a CRNA billed with modifier AD = \$162.76

Previously, HMO Blue Texas disallowed reimbursement for modifier AD. As of May 19, 2004, HMO Blue Texas will reimburse modifier AD at the maximum allowable rate indicated above.

Effective October 1, 2002, HMO Blue Texas Blue Cross and Blue Shield of Texas updated their total maximum allowable points for Vaginal or Cesarean delivery. 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.

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

**Max units as of October 1, 2002**

Obstetrical vaginal delivery		23 total maximum allowable points
Obstetrical Cesarean delivery		32 total maximum allowable points

**Max units prior to October 1, 2002**

Obstetrical Vaginal delivery		17 total maximum allowable points
Obstetrical Cesarean delivery		19 total maximum allowable points

*Note: The codes used in the articles included in this special mailing are subject to changes made by the owners of the codes sets (i.e. CPT, HCPCS, Revenue Codes, etc.).*

**SURGICAL CODES  
62310, 62311,  
62318 AND  
62319A**

**ANESTHESIA  
MODIFIER  
PAYMENT  
CHANGES**

**OB TIME & POINTS  
REIMBURSEMENT**





**REIMBURSEMENT  
OF OB ANESTHESIA  
ADD-ON CODES  
01968 AND 01969**

An error was made in the number of combined maximum units in the article titled "Reimbursement of OB Anesthesia Add on codes 01968 and 01969" in the February 2004 Special Mailing for HMO Blue Texas and Blue Cross and Blue Shield of Texas. Below is the correction to the combined maximum units:

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 units for dates of service October 1, 2002 and after or allows a combined maximum of 19 units for dates of service prior to October 1, 2002.

**VENTILATOR  
MANAGEMENT IN  
CONJUNCTION WITH  
ANESTHESIA  
SERVICES  
(94656 AND 94657)**

REMINDER - 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.

Ventilation management 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 a 25 modifier. 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).

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.

**DAILY HOSPITAL  
MANAGEMENT OF  
EPIDURAL OR  
SUBARACHNOID  
CONTINUOUS DRUG  
ADMINISTRATION  
01996**

Effective May 19, 2004, HMO Blue Texas / Blue Cross and Blue Shield of Texas updated their maximum allowable for this code. This procedure is not allowed on the day of the operative procedure. Only one 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 days.

To clarify, the intrinsic value of this code is not changing. This change is specific to the number of times this code is billed each day. Not more than one unit of service will be allowed each day, starting on the first post-operative pain management, up to a maximum of three days. This procedure will not be allowed on the day of the operative procedure.

*Note: The codes used in the articles included in this special mailing are subject to changes made by the owners of the codes sets (i.e. CPT, HCPCS, Revenue Codes, etc.).*