BlueCross BlueShield of Texas

Anesthesia Payment & Billing Information

Anesthesia Services

Providers should refer to the Clinical Payment and Coding Policy **CPCP010 Anesthesia Information**.
The following is additional information when billing anesthesia services.

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 Modifier Reimbursement

BCBSTX maximum allowable fees for services billed as MD supervision of a Certified Registered Nurse Anesthetist (CRNA) or Anesthesia Assistant (AA) 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 BCBSTX 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.

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, BCBSTX allows a combined maximum of 32 points.

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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).

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.

***Note**: The codes referenced in the information above are subject to changes made by the owner of the code set (i.e., Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Revenue Codes, etc.).*

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