WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Provider Relations
Department
4000 House Avenue
PO Box 2266
Cheyenne, WY
82003
888-666-5188
www.bcbswy.com

Provider Highlights

BCBSWY Anesthesia Billing and Reimbursement Guidelines

Non-Covered Services

BCBSWY does not reimburse for:

- Physical status modifiers (P1 – P6)
- Qualifying Circumstances (CPT codes 99100 – 99135)
- Charges for the above services will be denied as included in the payment for the anesthesia service and may not be billed to the patient.

Emergency Anesthesia

- CPT 99140 (emergency anesthesia) is allowed in situations where a delay in treatment would lead to threat to life or body part. 99140 will not be allowed based solely on the time of day or because a procedure was not scheduled prior to the decision for surgery.

Labor/Deliver Anesthesia

- 01960 is allowed at base units only; no time units are allowed.
- 01967 is allowed at base units only; no time units are allowed. However base units are increased by 4 to allow for patient monitoring.
- Add-on codes 01968 and 01969 are allowed at base units plus time units. Time should be reported for only the cesarean portion of the procedure. **Note**: Add-on codes must be billed in addition to the code for the primary procedure performed on the same claim.
- 01961 is allowed at base units plus time.

Nerve (Pain) Blocks, Injections and Catheter Placement
(62320-62327, 64400-89, 64505-64530)

- Injections, blocks or catheter placements for post-operative pain management, and not as the means of surgical anesthesia, should be billed with modifier -59 to indicate these procedures were performed for post-operative pain management.
- If these procedures are performed **before the induction** or **after the conclusion** of the primary means of surgical anesthesia, the time spent on them should not be added to the reported anesthesia time.

(continued)



- If a catheter is placed, CPT 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. CPT 01996 is not reportable on the same DOS as the catheter placement. Reimbursement for daily pain management is limited to a maximum of 3 days.

Billing Guidelines

- Anesthesia services must be billed on a CMS 1500 with CPT codes 00100-01999.

- Units on the claim form (Box 24G) must be equal to the time anesthesia was administered in ***minutes***. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area, and ends when the anesthesiologist is no longer in personal attendance.

- When multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value should be reported. The time reported is the combined total for all procedures.

- Under no circumstances will two providers be paid for a single anesthesia administration. If anesthesiologists are in a group practice, one member may provide the pre-anesthesia examination while another performs other portions of the service. The medical record should indicate the services furnished and the provider who furnished them. However, only one member of the group would bill for the entire anesthesia service. The claim should be submitted under the NPI number of the provider who was in attendance during the majority of the anesthesia administration.

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