Supplement to current edition (September 2023) of the Blue Book℠ for Anesthesia Services

Effective October 1, 2026, Blue Cross Blue Cross and Blue Shield of North Carolina (Blue Cross NC) has made the following revisions regarding anesthesia services in section 9.66.1 on page 9-180, section 9.66.4 on page 9-181, and 9.68.2 on page 9-209 of the Blue Book ℠.

9.66.1 Anesthesia supplies and services Has Been Removed

9.66.4 Certified Registered Nurse Anesthetist Has Been Removed

9.68.2 Charge-to-charge comparison

Daily hospital service-acute care – Daily hospital service is recommended as a replacement for the phrase "room and board." Services and supplies included in the daily hospital service charge are:

a. Room and complete linen service. Examples include: Bath cloth, pillow case, soap, blanket, sheets, towels.

b. Dietary service: Meals, therapeutic diets, required nourishment, dietary consultation and diet exchange list. Dietary supplements are especially formulated products designed to increase the amount of various food elements required to maintain or to correct a deficiency, which may exist. Blue Cross NC certificates generally do not provide benefits for dietary supplements. These supplements are considered to be a part of daily hospital service and are not to be billed for separately either to Blue Cross NC nor to its participant/patient. Examples of dietary supplements and/or tube feeding supplements are: Ensure, Forta, Isocal, Osmolite, Sustagen, Vivonex.

c. General nursing services including patient education (e.g., instructions and materials). This does not include private duty nursing.

d. All equipment needed to weigh the patient (e.g., scales). A separate fee must not be billed to Blue Cross NC nor the participant/patient.

e. Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls and similar items used in the examination of patients.

f. Use of examining and/or treatment rooms for routine examinations.

g. Routine supplies provided as a part of routine care. Examples are: All tape, wipes, swabs, scrubs, bib, scales, body lotion, bedpans, bedside commode, urinals, toilet tissue, elevated toilet seat, air freshener, deodorizing machine, water pitcher, patient gown, facial tissues, emesis basin, breast pump and supplies, nursing pads, petroleum jelly, hydrogen peroxide,

alcohol, epsom salts, adult diapers, specimen traps, hot water bottles, ice bags, heating pads, humidifiers, vaporizers, limb restraints, chux and underpads.

h. Administration of enemas and medications including IV administration/infusion or IV ad mixture. Please note that the costs of the medication and administration sets are covered ancillary items.

i. Postpartum services.

j. Recreation therapy.

k. Enterostomal therapy. Please note that the costs of the enterostomal supplies are covered ancillary items.

For more information, please see reimbursement policy at BlueCrossNC.com/Providers/Policies-Guidelines-Codes/Medical-Policies.

Special monitoring equipment (e.g., dinemapp, swan ganz, cardiac, pressure monitor and telemetry) charges must include the use of the supplies (e.g., electrodes, guidewires and telemetry pouches). Special monitoring equipment charges may be billed separately when used by a patient in routine or general accommodations.

Special beds – Special beds are covered as a separate charge when medically necessary: a. Incontinence management system beds are not covered as separate line ancillaries. These beds are covered only as part of the approved daily hospital service charge.

b. Patient handling beds are covered as part of routine orthopedic care and are covered only in the daily accommodation allowance. Do not bill as a separate charge to Blue Cross NC nor our members.

c. High capacity beds for patients with weight recommendations are not covered. The charges for these beds should be billed to the patient as they are the patient's liability.

When the bed is covered, the charge must include the bed itself, the delivery fee, set up and scales.

Charges for special beds will be reimbursed as a flat fee and are not to be priced through the medical and surgical supply pricing formula. These beds must be billed using UB-04 revenue code 0946 or 0947.

Nursery – The services and supplies indicated in the daily hospital service charge for acute care are also included in the daily hospital service charge for nursery plus other similar items necessary in the routine care of infants such as bottles, diapers, baby powder, sterile safety pins, isolettes and radiant warmers.

Labor and delivery room – The labor room charge and delivery room charge each must include the cost of:

a. The use of the room.

b. The services of qualified technical personnel.

c. Linens, instruments, equipment and routine supplies.

The hospital must not bill the Plan for an obstetrics room in addition to the labor room fee when the patient is still in the labor room at time of census.

Psychiatric room – The psychiatric room charge includes the cost of all items listed in acute care as well as the following therapy services:

a. Adjunctive therapy

b. Art therapy

c. Group therapy

d. History and physical

e. Music therapy

f. Occupational therapy

g. Psychiatric social worker

h. Psychotherapy

i. Recreation therapy

Leave of absence days – Blue Cross NC does not provide coverage for therapeutic leave of absence days occurring during an inpatient admission whether in connection with the convenience of the patient or the treatment of the patient. This charge should be billed directly to the patient as it is the patient's liability. If billed on the UB-04 claim form, please use revenue code 0180.

Rehabilitation room – The rehabilitation room charge includes the cost of all items listed in acute care plus the psychiatric room therapy services listed above.

Critical care units – Critical care units represent special treatment areas of a hospital for critically ill patients. Care includes continuous observation by specially trained nurses and the availability of special equipment and life-saving techniques. To be considered a critical care unit, the unit must meet the following conditions:

a. The unit must be in the hospital.

b. The unit must be physically separate from general routine patient care areas and ancillary service areas.

c. There must be specific written policies that include criteria for admission to, and discharge from, the unit.

d. Registered nursing care must be furnished on a continuous twenty-four (24) hour basis. e. A minimum nurse-patient ratio of one (1) nurse to two (2) patients per patient day must be maintained.

f. The unit must be equipped, or have available for immediate use, lifesaving equipment necessary to treat the critically ill patients for whom it was designed. This equipment includes, but is not limited to, respiratory and cardiac monitoring equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.), cardiac defibrillators and wall or canister oxygen.

A critical care unit is not a post-operative recovery room or a post-anesthesia room.

The charge for a critical care unit, though generally stated as a single dollar amount, has two (2) components:

a. The room charge includes the cost of all items listed under acute care.

b. The nursing/equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel.

Ventilators are billable separate line ancillaries. The ventilator charge must include the use of the equipment and all supplies.

Recovery room – The charge for recovery room includes the costs of nursing personnel, routine equipment (e.g., oxygen) and supplies, monitoring equipment (e.g., blood pressure, cardiac and pulse oximeter), defibrillator, etc.

When a patient is using monitoring equipment in the recovery room and is transported to another ancillary department or a room, a separate monitoring equipment charge should not be billed for use of this equipment during transport. Monitoring equipment used during transport is considered a continuation of recovery room services.

Warming systems (e.g., Bair Hugger patient warming system, hypo/hyperthermic unit, radiant warmer, etc.) are considered part of the departmental overhead cost where it is used (e.g., recovery room). A separate fee must not be billed to Blue Cross NC nor the participant/patient.

Operating room – The operating room charge may be based on time or on a procedural basis. When time is the basis for arriving at the charge, it must be calculated from the induction of anesthesia to the completion of the procedure.

Standby services are not covered unless they are actually used.

Stereotactic radiosurgery – For our complete medical policy, refer to our website at BlueCrossNC.com.

Diagnostic services – The charges for radiology, CT scans, ultrasound, MRI, nuclear medicine and other diagnostic tests must include the use of a room, qualified technicians, films, dyes (e.g., ionic contrast agents, other enhancing agents) and supplies. Separate charges will be negotiated for injection fees and expensive dyes (e.g., non-ionic contrast agents).

- **Call-back and stat charges**

Call-back and stat charges are not to be billed just because they are incurred outside normal working hours. These charges are covered only when the procedure is ordered by the physician to be done immediately.

EKG – The charge for EKG services includes the use of a room, qualified technicians and supplies (e.g., electrodes, gel).

- **Cerebral death EEG**

Cerebral death EEG is not covered under our present Blue Cross NC certificates. This charge must not be billed as a separate line ancillary to Blue Cross NC.

- **Stat charges**

Stat charges must not be billed just because they are incurred outside normal working hours. These charges are to be billed to Blue Cross NC only when the procedure is ordered by the physician to be done immediately.

Lab/blood bank services – The charge for clinical laboratory must include the cost of all supplies related to the tests performed and a fee for the administration of the department. The charge for tissue (pathology) should include the cost of all supplies (e.g., arterial blood gas kits) related to the tests performed. Arterial puncture charge should be included in charge for test.

- **Stat charges**

Stat charges should not be billed just because they are incurred outside normal working hours. These charges should be billed to Blue Cross NC only when the procedure is ordered by the physician to be done immediately.

Handling/collection fee – Generally, Blue Cross NC does not cover handling/collection fees as separate line ancillaries.

American Red Cross (ARC) – Charges for blood units received from the ARC should include pass through costs from the ARC, minor supplies, administrative costs and additional lab tests performed on blood by the hospital.

Autologous blood – Charges for autologous donations are covered when such services are rendered for a specific purpose (e.g., surgery is scheduled or the need for using autologous blood is documented), and then only if the patient actually receives the blood.

Prophylactic autologous donations and long-term storage (e.g., freezing of components) for an indeterminate time period in case of future need are not considered eligible for benefits. Blood used must be billed on the same claim as the related surgery charges.

Directed blood donations – Directed blood donations (e.g., from relatives) are covered only to the extent that regular homologous blood donations are covered. No additional charges for directing the blood is covered. This would be the patient's liability.

Central supply – The medical and surgical supply pricing formula must cover the cost of the supplies and the cost of preparing, handling and storing the supplies.

Special supplies are those given directly to patients for whom a charge is made (e.g., sterile trays and the use of equipment).

General supplies are those used by other departments, the cost of which is included in the charge for the department where it is used, such as operating room supplies and daily hospital service supplies.

Isolation supplies – Isolation supplies related to patient care are covered when the patient must be isolated due to a contagious disease or infection. Isolation supplies used for the convenience or protection of visitors are not covered and should be billed directly to the patient.

Tampons, sanitary pads and sanitary belts are covered for OB/GYN patients only.

DME – Blue Cross NC certificates provide benefits for the rental of DME up to but not exceeding the total purchase price of the equipment. Charges for these items will be reimbursed as a flat fee and should not be priced through the medical and surgical supply pricing formula. Charges for durable medical equipment should be billed using UB-04 revenue code 0291 so that claims may be processed promptly and accurately.

Pharmacy – Generally, all drugs approved by the Food and Drug Administration are eligible for coverage with Blue Cross NC, subject to the member's benefits and the Plan's Utilization Management programs.

Pricing expensive drugs such as TPA using the pharmacy formula would not be reasonable. A separate mark-up may be negotiated for expensive drugs.

The pharmacy pricing formula must cover the cost of covered drugs prescribed by the attending physician, the cost of materials necessary for their preparation and administration, and the services of registered pharmacists and other pharmacy personnel. Medications furnished to patients must be billed at the negotiated rate with no additional charge either for the administration of drugs (e.g., IV admixture fee, dispensing fee, etc.) or to cover pharmacy overhead (e.g., pharmacy profile fee, drug assessment fee, dosage consultation, etc.).

Take-home drugs – Blue Cross NC certificates do not provide inpatient or patient hospital benefits for take-home items. Benefits are provided for take-home items by comprehensive and supplemental major medical and extended benefits when these items are properly identified on the claim. Please use UB-04 revenue code 0253 when billing for prescriptions filled by the pharmacy for take-home use.

Inhalation therapy – The charge established for this service must include the use of any special room, qualified technicians and supplies.

Physical therapy – The charge must include the use of a room, qualified technicians and all supplies related to the procedure. These charges may be established on a per treatment basis, a modality basis or a time basis. Physical therapy services are limited to one (1) hour of treatment and/or evaluation and may include up to four (4) modalities on a given day. To be considered eligible for coverage, the physical therapy services must be delivered by a qualified provider. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered physical therapy services should be billed using UB-04 revenue code 04X.

Activities in daily living and home programs – Activities in daily living and/or home programs instructions are not covered under the present Blue Cross NC certificates. These services should be billed to the patient as they are the patient's liability.

Occupational therapy – Occupational therapy is physical medicine primarily directed to restoration of functional activities and coordination, and prevention of deformities through exercise, muscle strengthening, retraining and/or re-education. Occupational therapy services are limited to one (1) hour of treatment and/or evaluation on a given day.

Occupational therapy is a covered ancillary when ordered by a doctor and delivered by a qualified provider of occupational therapy services to restore function following stroke, trauma,

surgery or congenital conditions. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered occupational therapy services should be billed using UB-04 revenue code 043X.

Occupational therapy is not a covered ancillary when used in the treatment of mental and nervous illnesses. In these cases, it is considered a part of daily general services and reimbursed by the daily accommodation and general services allowance.

Speech therapy – Speech therapy is treatment for the correction of speech impairment resulting from disease, surgery, injury or congenital anomaly. Speech therapy is covered when services are directed toward treatment of a specific disease, injury or congenital anomaly and services are expected to result in a significant and measurable improvement in functional capabilities within a reasonable and defined period of time.

To be considered eligible for coverage, these services must be delivered by a qualified provider. A qualified provider is one who is licensed where required and is performing within the scope of the license. Covered speech therapy services should be billed using UB-04 revenue code 044X.

Consultations/evaluations – Consultations/evaluations for physical therapy, inhalation therapy, occupational therapy and speech therapy are covered only if they are actually for tests and measurements with appropriate reports. However, if the evaluation is just a consultation, it is not covered.

Outpatient services

Outpatient cardiac rehabilitation programs – Blue Cross NC reimburses hospitals for outpatient cardiac rehabilitation programs only when the programs are certified by the North Carolina Cardiac Rehabilitation plan. Covered outpatient services should be billed using UB-04 revenue code 0943.

(Inpatient cardiac rehabilitation is considered part of routine care for a cardiac patient and is reimbursed through the daily hospital service charge.)

1. The outpatient cardiac rehabilitation program must be certified by the North Carolina Cardiac Rehabilitation plan.

Outpatient diabetes program

Blue Cross NC provides reimbursement for outpatient diabetes self-care services. Reimbursement will be made for the three (3) types of services listed below. One (1) total charge should be made for each program, not a per visit charge:

a. Outpatient diabetic self-care program: Three to six (3–6) hours of individual counseling for survival skills to include medication administration, diet basics, potential emergencies (e.g., diabetic, ketosis, hypoglycemia, acute illness) and glucose testing.

b. Comprehensive outpatient diabetic self-care program: Twelve to sixteen (12–16) hours (with a minimum of four [4] hours of individual counseling) to include pre- and post-assessment, review of survival skills, medication adjustment, exercise, pathophysiological teaching and preventive aspects.

c. Follow-up review of diabetic self-care program: Minimum of two (2) hours, to be performed at six (6) months, twelve (12) months and annually thereafter.

Covered services should be billed using UB-04 revenue code 0942 or 0949.

(Inpatient diabetes education – Admissions solely for the purpose of diabetic teaching are not covered under our present certificates.)

Outpatient multiple cardiological procedures – When multiple diagnostic cardiovascular services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 75%.

Outpatient multiple ophthalmological procedures – When multiple diagnostic ophthalmology services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 80%.

Outpatient multiple radiological procedures – When multiple radiological procedures are performed during the same outpatient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 50%. The allowance for the professional component of the primary procedure is 100%. The allowance for the professional component of the second and each subsequent imaging procedure is 95%.

Dietary/nutrition services – Dietary evaluation and other nutritional assessment services (e.g., Optifast) are non-covered under our present Blue Cross NC certificates. If included on the UB-04 claim form, please use UB-04 revenue code 0940.

Autopsy and morgue fee – Autopsy and morgue fees are not covered under our present Blue Cross NC certificates.

Transport services – Transport services (e.g., nurse transport, attendant's fee and nursing support) are not covered under our present Blue Cross NC certificates. We would expect

services necessary to transport the patient to be provided by the ambulance service. These charges should be billed directly to the patient as they are the patient's liability. The patient may then submit a claim for individual consideration using the subscriber submitted claim form. The patient can obtain this form from their nearest Blue Cross NC service office.

Mobile services – Mobile cardiac catheterization and mobile lithotripsy services will be reimbursed through all-inclusive fees.

Lithotripsy – ESWL is a generally accepted medical practice for removal of stones in the renal calyx, pelvis and upper half of the ureter when the following indications are present: a. Patient would undergo a surgical procedure to remove the stone if ESWL were not performed. b. Stones are at least three (3) millimeters in diameter. c. The stone-containing kidney is functional. d. Contraindications are not present.

Treatment of stones that are asymptomatic or likely to pass spontaneously is not medically necessary.

The Plan expects stones of the size 1-1/2 cm or less to be successfully removed by a single ESWL treatment. Therefore, there will be no additional reimbursement for professional or hospital charge for subsequent treatments of stones that were originally 1-1/2 cm or less in size unless documentation of extenuating circumstances is provided.

Extracorporeal shock wave lithotripsy devices for gallstones have not received FDA approval; therefore, ESWL for gallstones is considered investigational and is not covered by Blue Cross NC. Charges for this service should be billed to the patient