ANESTHESIA
Procedure Codes

eMedNY New York State Medicaid Provider Procedure
Code Manual

New York State Medicaid
Office of Health Insurance
Department of Health

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1   DOCUMENT CONTROL PROPERTIES

Control Item	Value
Document Name	**Anesthesia Procedure Codes**
Document Control Number	2024-1
Document Type	Procedure Code Manual
Document Version	2024-V1
Document Status	
Effective date	April 2024

2   ANESTHESIA GENERAL INFORMATION AND RULES

A. Only anesthesiologists may be reimbursed for anesthesia services performed or provided by themselves or their supervised designees under the codes listed in this section.

B. The total values for anesthesia services include pre- and post- operative visits, the administration of the anesthetic and the administration of fluids and/or blood incident to the anesthesia or surgery.

C. Calculated values for anesthesia services are to be used only when the anesthesia is administered by an anesthesiologist or supervised designee who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

1. Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.
2. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

D. To bill for anesthesia time, report the total time in minutes in the unit's field. The maximum conversion factor is $10.00 per each 15 minutes. Do not include Basic Value in the reported minutes.

E. Anesthesia Report (or Operative Record) must document total time spent with the patient and include starting time, completion time and an explanation of any unusual occurrence which prolonged anesthesia time. If your claim is rejected for anesthesia exceeding the maximum, you can resubmit a paper claim with documentation supporting the time billed.

F. When more than one anesthesiologist is billing due to attending in shifts, only the first anesthesiologist will be reimbursed the Basic Value.

G. When multiple or bilateral surgical procedures, which add time and complexity to patient care, are performed at the same operative session, the total anesthesia time should be indicated in minutes using only the anesthesia procedure with the highest base value. Basic Values are listed in the Fee Schedule.

H. When hypothermia and/or a pump oxygenator are employed in conjunction with an anesthetic, see procedure code(s) 99116, 99190, 99191, 99192.

I. No fee will be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

J. The basic value for anesthesia covers services rendered from the time the anesthesiologist (or his/her associate) meets the patient in pre-operative holding until the patient is signed out of the post anesthesia care unit by the attending anesthesiologist (or his/her associate), this includes the insertion of epidural catheters or the administration of nerve blocks done in this time frame for post-operative pain control.

K. Administration of a nerve block (either as a component of the anesthesia itself or a post-operative pain management protocol) is considered part of the anesthesia time for surgery. This will not be reimbursed as a separate and distinct procedural service when performed by the same provider (or his/her associate) that has provided the anesthesia for the surgical procedure itself. Post op visits are included in the total value for anesthesia services as per rule #2 above.

L. Anesthesia services not connected with surgery will be found in other sections of the Physician manual.

3   MMIS ANESTHESIA MODIFIERS:

Note: NCCI associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/

23   Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier 23 to the procedure code of the basic service.

AD   Medical Supervision by a Physician: More Than Four Concurrent Anesthesia Procedures (performed by residents, CRNAs or a combination of both): Teaching anesthesiologists involved in furnishing more than 4 procedures concurrently or performing other services while directing concurrent procedures, will be allowed to bill at the "medical supervision" rate of 3 base units per procedure. Such cases would be appended with the "AD" modifier (medical supervision by a physician: more than 4 concurrent anesthesia procedures)

GC   This Service has Been Performed in Part by a Resident Under the Direction of a Teaching Physician: The modifier is used for those cases in which the teaching anesthesiologist is involved in single anesthesia case with a resident, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case that does not involve a resident (involves a CRNA). Reimbursement to the teaching/supervising anesthesiologist for the resident case(s) will be paid at 100%.

Note: The provision to pay teaching anesthesiologists 100% is strictly limited to involvement in a maximum of two resident cases only. If the anesthesiologist is involved in greater than two resident cases concurrently, bill with modifier QK, (see below).

QK   Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals (Residents, 1 or More CRNAs or a Combination of Both): The modifier is to be used when the teaching anesthesiologist is medically directing more than two resident cases concurrently. Reimbursement to the medically directing anesthesiologist for the resident case(s) will be at 50%.

The modifier is also used for the medical direction of CRNAs, when the CRNAs are self-employed or employed by the facility. Reimbursement to the medically directing anesthesiologist for the CRNA case(s) will be at 50%.

Note: When CRNAs, employed an anesthesiologist or an anesthesiology group, provide services under the medical direction of an employing anesthesiologist, the "QK" modifier should not be used. The anesthesia CPT code should be billed without a modifier under the National Provider Identification (NPI) number of the anesthesiologist or the anesthesiology group. Reimbursement to the medically directing anesthesiologist (or to the anesthesia group) for the CRNA case(s) will be at 100%.

TERMS applicable to the above modifiers:

"Teaching rules" require that the teaching anesthesiologist be present for all critical or key portions of the case.

"Medical direction" requires that the following seven conditions be met. The physician must perform the following activities:

- Perform a pre-anesthesia examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence;
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

"Medical supervision" is the term for medical direction of more than four concurrent anesthesia cases. It may also be used to bill for cases that start out as "medically directed," but in which the anesthesiologist becomes involved in other activities and is, therefore, unable to fulfill all seven requirements of medical direction.

4   ANESTHESIA SERVICES

4.1 HEAD

Code	Description
00100	Anesthesia for procedures on salivary glands, including biopsy
00102	Anesthesia for procedures involving plastic repair of cleft lip
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)
00104	Anesthesia for electroconvulsive therapy
00120	Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified
00124	otoscopy
00126	tympanotomy
00140	Anesthesia for procedures on eye; not otherwise specified
00142	lens surgery
00144	corneal transplant
00145	vitreoretinal surgery

00147	iridectomy
00148	ophthalmoscopy
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified
00162	radical surgery
00164	biopsy, soft tissue
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified
00172	repair of cleft palate
00174	excision of retropharyngeal tumor
00176	radical surgery
00190	Anesthesia for procedures on facial bones or skull; not otherwise specified
00192	radical surgery (including prognathism)
00210	Anesthesia for intracranial procedures; not otherwise specified
00211	craniotomy or craniectomy for evacuation of hematoma
00212	subdural taps
00214	burr holes, including ventriculography
00215	cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)
00216	vascular procedures
00218	procedures in sitting position
00220	cerebrospinal fluid shunting procedures
00222	electrocoagulation of intracranial nerve

4.2 NECK

00300	Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified
00320	Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older
00322	needle biopsy of thyroid
00326	Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified
00352	simple ligation

4.3 THORAX (CHEST WALL and SHOULDER GIRDLE)

00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified
00402	reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)
00404	radical or modified radical procedures on breast
00406	radical or modified radical procedures on breast with internal mammary node dissection
00410	electrical conversion of arrhythmias
00450	Anesthesia for procedures on clavicle and scapula; not otherwise specified
00454	biopsy of clavicle
00470	Anesthesia for partial rib resection; not otherwise specified

00472   thoracoplasty (any type)
00474   radical procedures (eg, pectus excavatum)

4.4 INTRATHORACIC
00500   Anesthesia for all procedures on esophagus
00520   Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified
00522   needle biopsy of pleura
00524   pneumocentesis
00528   mediastinoscopy and diagnostic thoracoscopy not utilizing 1 lung ventilation
00529   mediastinoscopy and diagnostic thoracoscopy utilizing 1 lung ventilation
00530   Anesthesia for permanent transvenous pacemaker insertion
00532   Anesthesia for access to central venous circulation
00534   Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator
00537   Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation
00539   Anesthesia for tracheobronchial reconstruction
00540   Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified
00541   utilizing 1 lung ventilation
00542   decortication
00546   pulmonary resection with thoracoplasty
00548   intrathoracic procedures on the trachea and bronchi
00550   Anesthesia for sternal debridement
00560   Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator
00561   with pump oxygenator, younger than 1 year of age
00562   with pump oxygenator, age 1 year or older, for all non-coronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation
00563   with pump oxygenator with hypothermic circulatory arrest
00566   Anesthesia for direct coronary artery bypass grafting; without pump oxygenator
00567   with pump oxygenator
00580   Anesthesia for heart transplant or heart/lung transplant

4.5 SPINE and SPINAL CORD
00600   Anesthesia for procedures on cervical spine and cord; not otherwise specified
00604   procedures with patient in the sitting position
00620   Anesthesia for procedures on thoracic spine and cord; not otherwise specified
00625   Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; not utilizing 1 lung ventilation
00626   utilizing 1 lung ventilation
00630   Anesthesia for procedures in lumbar region; not otherwise specified

00632   lumbar sympathectomy
00635   diagnostic or therapeutic lumbar puncture
00640   Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine
00670   Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)

4.6 UPPER ABDOMEN

00700   Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified
00702   percutaneous liver biopsy
00730   Anesthesia for procedures on upper posterior abdominal wall
00731   Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to the duodenum; not otherwise specified
00732   endoscopic retrograde cholangiopancreatography (ERCP)
00750   Anesthesia for hernia repairs in upper abdomen; not otherwise specified
00752   lumbar and ventral (incisional) hernias and/or wound dehiscence
00754   omphalocele
00756   transabdominal repair of diaphragmatic hernia
00770   Anesthesia for all procedures on major abdominal blood vessels
00790   Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified
00792   partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)
00794   pancreatectomy, partial or total (eg, Whipple procedure)
00796   liver transplant (recipient)
00797   gastric restrictive procedure for morbid obesity

4.7 LOWER ABDOMEN

00800   Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified
00802   panniculectomy
00811   Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to the duodenum; not otherwise specified
00812   screening colonoscopy
00813   Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal and distal to the duodenum
00820   Anesthesia for procedures on lower posterior abdominal wall
00830   Anesthesia for hernia repairs in lower abdomen; not otherwise specified
00832   ventral and incisional hernias
00834   Anesthesia for hernia repairs in the lower abdomen not otherwise specified, younger than 1 year of age
00836   Anesthesia for hernia repairs in the lower abdomen not otherwise specified,
00840   Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00842   amniocentesis
00844   abdominoperineal resection

00846	radical hysterectomy
00848	pelvic exenteration
00851	tubal ligation/transection
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified
00862	renal procedures, including upper one-third of ureter, or donor nephrectomy
00864	total cystectomy
00865	radical prostatectomy (suprapubic, retropubic)
00866	adrenalectomy
00868	renal transplant (recipient)
00870	cystolithotomy
00872	Anesthesia for lithotripsy, extracorporeal shock wave; with water bath
00873	without water bath
00880	Anesthesia for procedures on major lower abdominal vessels; not otherwise specified
00882	inferior vena cava ligation

4.8 PERINEUM

00902	Anesthesia for; anorectal procedure
00904	radical perineal procedure
00906	vulvectomy
00908	perineal prostatectomy
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified
00912	transurethral resection of bladder tumor(s)
00914	transurethral resection of prostate
00916	post-transurethral resection bleeding
00918	with fragmentation, manipulation and/or removal of ureteral calculus
00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified
00921	vasectomy, unilateral or bilateral
00922	seminal vesicles
00924	undescended testis, unilateral or bilateral
00926	radical orchiectomy, inguinal
00928	radical orchiectomy, abdominal
00930	orchiopexy, unilateral or bilateral
00932	complete amputation of penis
00934	radical amputation of penis with bilateral inguinal lymphadenectomy
00936	radical amputation of penis with bilateral inguinal and iliac lymphadenectomy
00938	insertion of penile prosthesis (perineal approach)
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
00942	colpotomy, vaginectomy, colporrhaphy, and open urethral procedure
00944	vaginal hysterectomy
00948	cervical cerclage

00950	culdoscopy
00952	hysteroscopy and/or hysterosalpingography

4.9 PELVIS (EXCEPT HIP)

01112	Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest
01120	Anesthesia for procedures on bony pelvis
01130	Anesthesia for body cast application or revision
01140	Anesthesia for interpelviabdominal (hindquarter) amputation
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation
01160	Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint
01170	Anesthesia for open procedures involving symphysis pubis or sacroiliac joint
01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum

4.10   UPPER LEG (EXCEPT KNEE)

01200	Anesthesia for all closed procedures involving hip joint
01202	Anesthesia for arthroscopic procedures of hip joint
01210	Anesthesia for arthroscopic procedures of hip joint
01212	hip disarticulation
01214	total hip arthroplasty
01215	revision of total hip arthroplasty
01220	Anesthesia for all closed procedures involving upper two-thirds of femur
01230	Anesthesia for open procedures involving upper two-thirds of femur; not otherwise specified
01232	amputation
01234	radical resection
01250	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg
01260	Anesthesia for all procedures involving veins of upper leg, including exploration
01270	Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified
01272	femoral artery ligation
01274	femoral artery embolectomy

4.11   KNEE and POPLITEAL AREA

01320	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area
01340	Anesthesia for all closed procedures on lower one-third of femur
01360	Anesthesia for all open procedures on lower one-third of femur
01380	Anesthesia for all closed procedures on knee joint
01382	Anesthesia for diagnostic arthroscopic procedures of knee joint
01390	Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella
01392	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise

specified

01402	total knee arthroplasty
01404	disarticulation at knee
01420	Anesthesia for all cast applications, removal, or repair involving knee joint
01430	Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified
01432	arteriovenous fistula
01440	Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified
01442	popliteal thromboendarterectomy, with or without patch graft
01444	popliteal excision and graft or repair for occlusion or aneurysm

4.12   LOWER LEG (BELOW KNEE, INCLUDES ANKLE and FOOT)

01462	Anesthesia for all closed procedures on lower leg, ankle, and foot
01464	Anesthesia for arthroscopic procedures of ankle and/or foot
01470	Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified
01472	repair of ruptured Achilles tendon, with or without graft
01474	gastrocnemius recession (eg, Strayer procedure)
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01482	radical resection (including below knee amputation)
01484	osteotomy or osteoplasty of tibia and/or fibula
01486	total ankle replacement
01490	Anesthesia for lower leg cast application, removal, or repair
01500	Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified
01502	embolectomy, direct or with catheter
01520	Anesthesia for procedures on veins of lower leg; not otherwise specified
01522	venous thrombectomy, direct or with catheter

4.13   SHOULDER and AXILLA

01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
01620	Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint
01622	Anesthesia for diagnostic arthroscopic procedures of shoulder joint
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01634	shoulder disarticulation
01636	interthoracoscapular (forequarter) amputation
01638	total shoulder replacement
01650	Anesthesia for procedures on arteries of shoulder and axilla; not otherwise specified
01652	axillary-brachial aneurysm

01654	bypass graft
01656	axillary-femoral bypass graft
01670	Anesthesia for all procedures on veins of shoulder and axilla
01680	Anesthesia for shoulder cast application, removal or repair; not otherwise specified

4.14 UPPER ARM and ELBOW

01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
01712	tenotomy, elbow to shoulder, open
01714	tenoplasty, elbow to shoulder
01716	tenodesis, rupture of long tendon of biceps
01730	Anesthesia for all closed procedures on humerus and elbow
01732	Anesthesia for diagnostic arthroscopic procedures of elbow joint
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified
01742	osteotomy of humerus
01744	repair of nonunion or malunion of humerus
01756	radical procedures
01758	excision of cyst or tumor of humerus
01760	total elbow replacement
01770	Anesthesia for procedures on arteries of upper arm and elbow; not otherwise specified
01772	embolectomy
01780	Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified
01782	phleborrhaphy

4.15 FOREARM, WRIST, and HAND

01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01820	Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones
01829	Anesthesia for diagnostic arthroscopic procedures on the wrist
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01832	total wrist replacement
01840	Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified
01842	embolectomy
01844	Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)
01850	Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified
01852	phleborrhaphy
01860	Anesthesia for forearm, wrist, or hand cast application, removal, or repair

4.16 RADIOLOGICAL PROCEDURES

01916	Anesthesia for diagnostic arteriography/venography
01920	Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)
01922	Anesthesia for non-invasive imaging or radiation therapy
01924	Anesthesia for therapeutic interventional radiological procedures involving the arterial system; not otherwise specified
01925	carotid or coronary
01926	intracranial, intracardiac, or aortic
01930	Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified
01931	intrahepatic or portal circulation (eg, transvenous intrahepatic portosystemic shunt[s] [TIPS])
01932	intrathoracic or jugular
01933	intracranial
01937	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic
01938	lumbar sacral
01939	Anesthesia for nerve destruction procedures on spine or spinal cord of neck or upper back accessed through skin using imaging guidance
01940	lumbar sacral
01941	Anesthesia for nerve modulation procedure spinal cord or repair of bone of spine of neck or upper back accessed through skin using imaging guidance
01942	lumbar sacral

4.17   BURN EXCISIONS or DEBRIDEMENT

01951	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than 4% total body surface area
01952	between 4% and 9% of total body surface area
01953	each additional 9% total body surface area or part thereof (List separately in addition to code for primary procedure)

4.18   OBSTETRIC

01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01962	Anesthesia for urgent hysterectomy following delivery
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
01965	Anesthesia for incomplete or missed abortion procedures
01966	Anesthesia for induced abortion procedures
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

01968   Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
(List separately in addition to code for primary procedure performed)

01969   Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia
(List separately in addition to code for primary procedure performed)

4.19   OTHER PROCEDURES

01991   Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position

01992   prone position

01996   Daily hospital management of epidural or subarachnoid continuous drug administration

01999   Unlisted anesthesia procedure(s)