

NEW YORK STATE

MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 6 – ANESTHESIA

Table of Contents

ANESTHESIA GENERAL INFORMATION AND RULES	3
ANESTHESIA SERVICES.....	6
HEAD.....	6
NECK.....	6
THORAX (CHEST WALL and SHOULDER GIRDLE).....	7
INTRATHORACIC	7
SPINE and SPINAL CORD	8
UPPER ABDOMEN	8
LOWER ABDOMEN	8
PERINEUM	9
PELVIS (EXCEPT HIP).....	10
UPPER LEG (EXCEPT KNEE)	10
KNEE and POPLITEAL AREA	10
LOWER LEG (BELOW KNEE, INCLUDES ANKLE and FOOT).....	11
SHOULDER and AXILLA.....	11
UPPER ARM and ELBOW.....	12
FOREARM, WRIST, and HAND.....	12
RADIOLOGICAL PROCEDURES	12
BURN EXCISIONS or DEBRIDEMENT	13
OBSTETRIC	13
OTHER PROCEDURES	14

ANESTHESIA GENERAL INFORMATION AND RULES

1. Only anesthesiologists may be reimbursed for anesthesia services performed or provided by themselves or their supervised designees under the codes listed in this section.
2. 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.
3. 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.

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. 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.

4. 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.
5. 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.
6. When more than one anesthesiologist is billing due to attending in shifts, only the first anesthesiologist will be reimbursed the Basic Value.
7. 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.
8. When hypothermia and/or a pump oxygenator are employed in conjunction with an anesthetic, see procedure code(s) 99116, 99190, 99191, 99192.
9. No fee will be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

Physician – Procedure Codes, Section 6– Anesthesia

10. 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.
11. 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.
12. Anesthesia services not connected with surgery will be found in other sections of the Physician manual.

13. 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%.

Physician – Procedure Codes, Section 6– Anesthesia

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.

ANESTHESIA SERVICES**HEAD**

- 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 otосcopy
- 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

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

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)

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

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)

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

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

Physician – Procedure Codes, Section 6– Anesthesia

- 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

PERINEUM

- 00902 Anesthesia for; anorectal procedure
- 00904 radical perineal procedure
- 00906 vulvectomy
- 00908 perineal prostatectomy
- 00910 Anesthesia for transurethral procedures (including urethroscopy); 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

Physician – Procedure Codes, Section 6– Anesthesia

- 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

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

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

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

Physician – Procedure Codes, Section 6– Anesthesia

- 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

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

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

Physician – Procedure Codes, Section 6– Anesthesia

- 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

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

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

RADIOLOGICAL PROCEDURES

- 01916 Anesthesia for diagnostic arteriography/venography
(Do not report 01916 in conjunction with therapeutic codes 01924-01926, 01930-01933)
- 01920 Anesthesia for cardiac catheterization including coronary angiography and ventriculography
(not to include Swan-Ganz catheter)

Physician – Procedure Codes, Section 6– Anesthesia

- 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

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)
(Use 01953 in conjunction with 01952)

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)
(Use 01968 in conjunction with 01967)

Physician – Procedure Codes, Section 6– Anesthesia

- 01969 Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
(Use 01969 in conjunction with 01967)

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)