NEW YORK STATE

MEDICAID PROGRAM

PHYSICIAN – PROCEDURE CODES

SECTION 6 – ANESTHESIA

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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 starts with the beginning of the administration of the anesthetic agents and ends when the anesthesiologist is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).

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.

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%.

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	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

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

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 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

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

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

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)

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
01935 Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic
01936 therapeutic

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)
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)