Anesthesia for procedures on salivary glands, including biopsy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
42300, 42305, 42320, 42325, 42326, 42330, 42335, 42340, 42400, 42405, 42408, 42410, 42415, 42420, 42425, 42440, 42507, 42508, 42509, 42510, 42550, 42600, 42650, 42660, 42665, 42725

ICD-9-CM Diagnostic Codes
- Malignant neoplasm of parotid gland (142.0)
- Malignant neoplasm of submandibular gland (142.1)
- Malignant neoplasm of sublingual gland (142.2)
- Malignant neoplasm of other major salivary glands (142.8)
- Malignant neoplasm of salivary gland, unspecified (142.9)
- Malignant neoplasm of floor of mouth, part unspecified (144.9)
- Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck (196.0)
- Secondary malignant neoplasm of other specified sites (198.89)
- Benign neoplasm of major salivary glands (210.2)
- Benign neoplasm of floor of mouth (210.3)
- Benign neoplasm of other and unspecified parts of mouth (210.4)
- Carcinoma in situ of lip, oral cavity, and pharynx (230.0)
- Neoplasm of uncertain behavior of major salivary glands (235.0)
- Neoplasm of uncertain behavior of lip, oral cavity, and pharynx (235.1)
- Neoplasm of uncertain behavior, site unspecified (238.9)
- Neoplasm of unspecified nature of digestive system (239.0)
- Hypertrophy of salivary gland (257.1)
- Sialoadenitis (257.2)
- Abscess of salivary gland (257.3)
- Fistula of salivary gland (257.4)
- Sialolithiasis (257.5)
- Mucocele of salivary gland (257.6)
- Disturbance of salivary secretion (257.7)
- Other specified diseases of the salivary glands (257.8)
- Cellulitis and abscess of oral soft tissues (258.3)
- Sjögren syndrome (750.24)
- Congenital fistula of salivary gland (784.2)
- Swelling, mass, or lump in head and neck (785.6)
- Enlargement of lymph nodes (786.5)
- Dysphagia, unspecified (787.20)
- Dysphagia, oral phase (787.21)
- Dysphagia, oropharyngeal phase (787.22)
- Dysphagia, pharyngeal phase (787.23)
- Dysphagia, pharyngoesophageal phase (787.24)
- Other dysphagia (787.29)
- Open wound of cheek, complicated (837.51)
- Open wound of face, other and multiple sites, complicated (873.59)
- Open wound of buccal mucosa, without mention of complication (873.61)
- Open wound of mouth, other and multiple sites, without mention of complication (873.69)
- Late effect of open wound of head, neck, and trunk (906.0)
- Persistent postoperative fistula, not elsewhere classified (996.6)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for procedures involving plastic repair of cleft lip

Coding Tips
Do not report code 00102 for procedures performed on the lip for conditions other than repair of cleft lip. For other, non-cleft-lip repairs, see code 00300. For cleft palate repairs, see 00172. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- cleft lip: Congenital fissure or opening in the upper lip due to failure of embryonic cells to fuse completely.
- congenital: Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
- fissure: Deep furrow, groove, or cleft in tissue structures.

Surgical to Anesthesia Code Crosswalk
40700, 40701, 40720, 40721

ICD-9-CM Diagnostic Codes
749.10 Unspecified cleft lip
749.11 Unilateral cleft lip, complete
749.12 Unilateral cleft lip, incomplete
749.13 Bilateral cleft lip, complete
749.14 Bilateral cleft lip, incomplete
749.20 Unspecified cleft palate with cleft lip
749.21 Unilateral cleft palate with cleft lip, complete
749.22 Unilateral cleft palate with cleft lip, incomplete
749.23 Bilateral cleft palate with cleft lip, complete
749.24 Bilateral cleft palate with cleft lip, incomplete
749.25 Other combinations of cleft palate with cleft lip
V13.69 Personal history of other (corrected) congenital malformations
V51.8 Other aftercare involving the use of plastic surgery

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3.4; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00103

Anesthesia for reconstructive procedures of eyelid (e.g., blepharoplasty, ptosis surgery)

Coding Tips
For nonreconstructive procedures on the eye, see 00140-00148. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
blepharoplasty. Plastic surgery of the eyelids to remove excess fat and redundant skin weighing down the lid. The eyelid is pulled tight and sutured to support sagging muscles.

ptosis. Drooping or displacement of the upper eyelid, caused by paralysis, muscle problems, or outside mechanical forces.

Surgical to Anesthesia Code Crosswalk
15820, 15821, 15822, 15823, 67700, 67710, 67715, 67825, 67830, 67835, 67880, 67882, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67912, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67930, 67935, 67938, 67950, 67961, 67966, 67971, 67973, 67974, 67975

ICD-9-CM Diagnostic Codes

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<td>Blepharospasm — (Use additional E code to identify drug, if drug-induced)</td>
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<td>351.8</td>
<td>Other facial nerve disorders</td>
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<td>374.32</td>
<td>Myogenic ptosis</td>
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<td>374.34</td>
<td>Blepharochalasis</td>
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CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Coding and Payment Guide for Anesthesia Services

00104

00104 Anesthesia for electroconvulsive therapy

Coding Tips
Code 00104 may be denied when multiple electroconvulsive therapy (ECT) is provided. ECT (90870) is a noncovered service by Medicare. Therefore, when anesthesia is performed for this reason, it will be denied as noncovered. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers. Schizophrenia is not diagnosed unless there is characteristic disturbance of at least two of these areas: thought, perception, mood, conduct, and personality. The first axis of coding schizophrenia is to identify the type (i.e., simple, disordered, paranoid, latent, residual, etc.). The second is to identify the course of illness with a fifth digit. Episodic mood disorders (category 296) are recurrent, severe disturbances of mood accompanied by one or more of the following: delusions, perplexity, disturbed attitude to self, disorder of perception, and behavior. Patients with affective disorders have a strong tendency toward suicide. This category includes mild disorders of mood if the symptoms closely match the descriptions. Subcategories identify the type (e.g., manic or major depressive, bipolar, etc.) and episodic nature (e.g., single, recurrent, etc.).

Terms To Know
bipolar disorder. Manic-depressive psychosis that has appeared in both the depressive and manic form, either alternating or separated by an interval of normality. Atypical: Episode of affective psychosis with some, but not all, of the features of the one form of the disorder in individuals who have had a previous episode of the other form of the disorder.

depression. Disproportionate depressive state with behavior disturbance that is usually the result of a distressing experience and may include preoccupation with the psychic trauma and anxiety.
schizophrenia. Fundamental disturbance of personality and characteristic distortion of thinking, often a sense of being controlled by alien forces, delusions, disturbed perception, abnormal affect out of keeping with the real situation, and auditory or visual hallucinations with fear that intimate thoughts, feelings, and acts are known by others although clear consciousness and intellectual capacity are usually maintained.

Surgical to Anesthesia Code Crosswalk
90870, 90871

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00120-00126

00120  Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified

00124  otoscopy

00126  tympanotomy

Coding Tips
These are unilateral procedures. If they are performed bilaterally, some payers require that the surgical service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Only one anesthesia service (00100-01992, 01999) should be reported per surgical session. Payers may require supporting documentation substantiating the need for anesthesia when reporting 00124. Check with individual payers. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical directions) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
eustachian tube. Internal channel between the tympanic cavity and the nasopharynx that equalizes internal pressure to the outside pressure and drains mucous production from the middle ear.
o-. Relating to the ear.
pinna. Outer portion of the ear attached to the side of the head that collects sound by amplifying and directing the sound waves into the external auditory canal.
tympano-. Relating to the eardrum.
vertigo. Sensation of movement, either of one's own body or the environment rotating or spinning, due to a disturbance of the inner ear, vestibular centers, or pathways in the central nervous system. This condition often causes nausea and vomiting.

Surgical to Anesthesia Code Crosswalk
21230, 21235, 69000, 69005, 69020, 69100, 69110, 69120, 69140, 69145, 69150, 69200, 69205, 69210, 69220, 69222, 69300, 69310, 69320, 69405, 69410, 69420, 69424, 69433, 69436, 69440, 69450, 69501, 69502, 69505, 69511, 69530, 69535, 69540, 69550, 69552, 69601, 69602, 69603, 69604, 69605, 69610, 69620, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69643, 69644, 69645, 69650, 69660, 69661, 69662, 69666, 69667, 69670, 69676, 69700, 69710, 69711, 69720, 69725, 69740, 69745, 69801, 69802, 69805, 69806, 69820, 69840, 69905, 69910, 69915, 69930, 69960, 92502, 92505, 92584, S2230

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Also not with 00124: 76100

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<tr>
<th>Procedure Code</th>
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</table>
**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**Coding Tips**

Medicare coverage guidelines may consider general anesthesia in cataract surgery to be reasonable and necessary for particular medical indications if it is an accepted practice among ophthalmologists in the local community to use general anesthesia for those indications. These are unilateral procedures. If they are performed bilaterally, some payers require that the surgical service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Only one anesthesia service (00140-01992, 01999) should be reported per surgical session. Check with individual payers. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**

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Anesthesia for procedures on nose and accessory sinuses; not otherwise specified

radical surgery

biopsy, soft tissue

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
ethmoid bone. Cube-shaped bone located between the orbits.
frontal sinusotomy. Surgical procedure in which the anterior wall of the frontal sinus is excised, the diseased tissue removed, and a permanent opening is created between the nasal cavity and the maxillary sinus in order to facilitate sinus drainage.
mexillary. Located between the eyes and the upper teeth.
sinus. Open space, cavity, or channel within the body or abnormal cavity, fistula, or channel created by a localized infection to allow the escape of pus.
turbinates. Scroll or shell-shaped elevations from the wall of the nasal cavity, the inferior turbinate being a separate bone, while the superior and middle turbinates are of the ethmoid bone.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10,4; 100-4,4,10,5; 100-4,4,250,3,2; 100-4,4,250,3,3,1; 100-4,4,12,140,1; 100-4,4,12,140,3; 100-4,4,12,140,3,3; 100-4,4,12,140,3,4; 100-4,4,12,140,4,1; 100-4,4,12,140,4,2; 100-4,4,12,140,4,3; 100-4,4,12,140,4,4

CCI Version 20.0

<table>
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<th>CCI Code</th>
<th>Description</th>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for intraoral procedures, including biopsy; not otherwise specified

Coding Tips

Diagnosis coding is important to substantiate the coverage of code of this code. Anesthesia provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth is not covered by Medicare. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
gingiva. Soft tissues surrounding the crowns of unerupted teeth and necks of erupted teeth.
intra. Within.
nasopharynx. Membranous passage above the level of the soft palate.
palate. Partition that separates the nasal from the oral cavities.
periapical. Anatomical area around the terminal end of a tooth root.
vestibule of the mouth. Mucosal and submucosal tissue of the lips and cheeks within the oral cavity, not including the dentoalveolar structures.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.3.2; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for intraoral procedures, including biopsy; repair of cleft palate

**Coding Tips**

For cleft repair, see code 00102. Anesthesia provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth is noncovered by Medicare. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers. Cleft palate is the fissure or abnormal elongated opening of the palate. Cleft palate can occur either unilaterally or bilaterally and can be either partial or complete. The most common types of cleft palate are the complete left unilateral and partial midline cleft or the secondary palate. The dividing point between the primary and secondary palate is the incisive foramen. Fifth-digit assignment indicates laterality.

**Terms To Know**

- **cleft lip**: Congenital fissure or opening in the upper lip due to failure of embryonic cells to fuse completely.
- **cleft palate**: Congenital fissure or defect of the roof of the mouth opening to the nasal cavity due to failure of embryonic cells to fuse completely.
- **congenital**: Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
- **fissure**: Deep furrow, groove, or cleft in tissue structures.

**Surgical to Anesthesia Code Crosswalk**

42200, 42205, 42210, 42215, 42220, 42225

**ICD-9-CM Diagnostic Codes**

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<th>Code</th>
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<td>Unspecified cleft palate</td>
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<td>Bilateral cleft palate, incomplete</td>
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<td>749.13</td>
<td>Bilateral cleft lip, complete</td>
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<td>783.3</td>
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<td>Other voice and resonance disorders</td>
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**Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.**

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for intraoral procedures, including biopsy; excision of retropharyngeal tumor

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
41135, 41140, 41145, 41150, 41153, 41155, 42842, 42844, 42845, 42890, 42892, 42894

ICD-9-CM Diagnostic Codes

141.0 Malignant neoplasm of base of tongue
141.1 Malignant neoplasm of dorsal surface of tongue
141.2 Malignant neoplasm of tip and lateral border of tongue
141.3 Malignant neoplasm of ventral surface of tongue
141.4 Malignant neoplasm of anterior two-thirds of tongue, part unspecified
141.5 Malignant neoplasm of junctional zone of tongue
141.6 Malignant neoplasm of lingual tonsil
141.7 Malignant neoplasm of sublingual gland
141.8 Malignant neoplasm of anterior portion of floor of mouth
141.9 Malignant neoplasm of lateral portion of floor of mouth
145.6 Malignant neoplasm of retromolar area
145.9 Malignant neoplasm of mouth, unspecified site
146.0 Malignant neoplasm of mouth
146.1 Malignant neoplasm of tonsillar fossa
146.2 Malignant neoplasm of tonsillar pillars (anterior) (posterior)
146.3 Malignant neoplasm of vallecula
146.4 Malignant neoplasm of anterior aspect of epiglottis
146.5 Malignant neoplasm of junctional region of oropharynx
146.6 Malignant neoplasm of lateral wall of oropharynx
146.7 Malignant neoplasm of posterior wall of oropharynx
146.8 Malignant neoplasm of other specified sites of oropharynx
147.1 Malignant neoplasm of posterior wall of nasopharynx
147.2 Malignant neoplasm of lateral wall of nasopharynx
147.3 Malignant neoplasm of anterior wall of nasopharynx
148.1 Malignant neoplasm of pyriform sinus
170.1 Malignant neoplasm of mandible
171.0 Malignant neoplasm of connective and other soft tissue of head, face, and neck

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,4,12,140.1; 100-4,4,12,140.3; 100-4,4,12,140.3.1; 100-4,4,12,140.3.4; 100-4,4,12,140.4.1; 100-4,4,12,140.4.2; 100-4,4,12,140.4.3; 100-4,4,12,140.4.4

CCI Version 20.0
0178T-0179T, 0180T, 01996, 0213T, 0216T, 0228T, 0230T, 0282T-0283T, 0311T, 31505, 31515, 3155, 42842, 42844, 42845, 42890, 42892, 42894

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00190-00192

00190  Anesthesia for procedures on facial bones or skull; not otherwise specified

00192  radical surgery (including prognathism)

Coding Tips
Code 00190 is used to report anesthesia performed at the time of extradural procedures on the bone(s) of the skull such as excision of bone or removal of tumor. Code 00192 should be used when the documentation indicates procedures such as removal of malignant tumor or prognathism. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
enophthalmos. Condition in which the eyeball recedes backwards into the eye socket. Underlying causes include atrophy, trauma, or surgery. exophthalmos. Abnormal bulging or protrusion of the eyeballs, seen in cases of hyperthyroidism, like Grave’s disease and toxic diffuse goiter, or as a congenital condition. extradural. Located outside of the dura mater. mandible. Lower jawbone giving structure to the floor of the oral cavity. orbit. Bony cavity that contains the eyeball, formed by seven bones of the skull: frontal, sphenoid, maxilla, zygomatic, palatine, lacrimal, and ethmoid. prognathism. Condition in which the mandible protrudes abnormally with misalignment of the teeth. radical. Extensive surgery.

Surgical to Anesthesia Code Crosswalk
11012, 11044, 20660, 20661, 20664, 20665, 20670, 20694, 20982, 21010, 21025, 21026, 21029, 21030, 21031, 21032, 21034, 21040, 21041, 21044, 21045, 21046, 21047, 21048, 21049, 21050, 21060, 21070, 21073, 21076, 21077, 21079, 21100, 21116, 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209, 21210, 21215, 21230, 21240, 21242, 21243, 21244, 21245, 21246, 21247, 21248, 21249, 21255, 21256, 21260, 21263, 21267, 21270, 21275, 21295, 21296, 21300, 21338, 21339, 21340, 21343, 21344, 21345, 21346, 21347, 21348, 21355, 21356, 21360, 21365, 21366, 21385, 21386, 21387, 21390, 21395, 21400, 21401, 21406, 21407, 21408, 21421, 21422, 21423, 21431, 21432, 21433, 21435, 21436, 21440, 21445, 21450, 21451, 21452, 21453, 21454, 21461, 21462, 21465, 21470, 21480, 21485, 21490, 29800, 29804, 65112, 67420, 67430, 67440, 67445, 67450, 69714, 69715, 69717, 69718

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

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without hydrocephalus. Spina bifida is reported with a code from ICD-9-CM

Can be recognized by the presence of alpha-fetoproteins in the amniotic fluid

Spina bifida.

Optic nerve.

Area.

treatment method is to shunt the cerebrospinal fluid (CSF) to another body

cerebrospinal fluid pathways either congenital or acquired. The primary

treatment method is to shunt the cerebrospinal fluid (CSF) to another body

Dilation of the ventricles. Hydrocephalus is most often the result of obstructed

Hydrocephalus.

Internal or external bleeding with loss of significant amounts

Hemorrhage.

By a break in a blood vessel wall, usually as a result of trauma.

Hematoma.

Tumor-like collection of blood in some part of the body caused

by a break in a blood vessel wall, usually as a result of trauma.

Hemorrhage.

Optic nerve. Transmits visual information from the retina to the brain.

Spina bifida. Lack of closure in the vertebral column with protrusion of the

spinal cord through the defect, often in the lumbar sacral area. This condition

can be recognized by the presence of alpha-fetoproteins in the amniotic fluid and may present alone or in conjunction with other anomalies, and with or without hydrocephalus. Spina bifida is reported with a code from ICD-9-CM category 741, with a mandatory fifth digit specifying the location of the lesion.

Subarachnoid. Located below the arachnoid meningeal layer.

Subdural. Space between the dura matter and arachnoid in the brain.

Surgical to Anesthesia Code Crosswalk

0077T, 21261, 21263, 21268, 61304, 61312, 61313, 61314, 61315, 61320, 61322, 61323, 61330, 61332, 61333, 61334, 61340, 61440, 61450, 61460, 61470, 61480, 61490, 61500, 61501, 61510, 61512, 61514, 61516, 61519, 61526, 61531, 61533, 61534, 61535, 61536, 61537, 61538, 61539, 61540, 61541, 61542, 61543, 61544, 61545, 61546, 61548, 61550, 61552, 61556, 61557, 61558, 61559, 61563, 61564, 61566, 61567, 61570, 61571, 61575, 61576, 61580, 61581, 61582, 61583, 61584, 61585, 61586, 61590, 61591, 61592, 61595, 61596, 61597, 61598, 61600, 61601, 61605, 61606, 61607, 61608, 61615, 61616, 61618, 61619, 61720, 61750, 61751, 61760, 61770, 61860, 61862, 61863, 61867, 61870, 61875, 61880, 62010, 62100, 62115, 62117, 62121, 62142, 62143, 62145, 62161, 62162, 62163, 62164, 62165, 69950, 69970, 52103, 52235

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present


ICM References

100-4,10.4; 100-4,10.5; 100-4,250.3.2; 100-4,250.3.3.1;
100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4;
100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3;
100-4,12,140.4.4

CCI Version 20.0

01996, 0213T, 0216T, 0228T, 0230T, 0282T-0283T, 0311T, 0333T, 31505, 31515, 31527, 31622, 31634, 31645, 31647, 36000, 36010-36015, 36400-36410, 36420-36430, 36440, 36600, 36640, 43752-43754, 61026, 61055, 62010, 62100, 62115, 62117, 62121, 62142, 62143, 62145, 62161, 62162, 62163, 62164, 62165, 69950, 69970, 52103, 52235

IOM References

100-4,10.4; 100-4,10.5; 100-4,250.3.2; 100-4,250.3.3.1;
100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4;
100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3;
100-4,12,140.4.4

Terms To Know

cerebellum. Portion of the brain in the rear cranial fossa behind the brain

stem responsible for movement coordination.

cerebrum. Primary portion of the brain in the upper part of the cranial that

is the largest part of the central nervous system. It is divided into two

hemispheres connected by the corpus callosum with the hemispheres divided

into the frontal, parietal, temporal, occipital, and insular lobes. The functions of

the cerebrum include intelligence, personality, motor function, planning

and organization, and interpretation of sensory input.

cranietomy. Surgical excision of a portion of the skull.

craniotherapy. Surgical incision made into the cranium or skull for a number

of surgical reasons (e.g., decompression, implantation of electrode array, excision, etc.).

hematoma. Tumor-like collection of blood in some part of the body caused

by a break in a blood vessel wall, usually as a result of trauma.

hemorrhage. Internal or external bleeding with loss of significant amounts

of blood.

hydrocephalus. Abnormal buildup of cerebrospinal fluid in the brain, causing
dilation of the ventricles. Hydrocephalus is most often the result of obstructed
cerebrospinal fluid pathways either congenital or acquired. The primary
treatment method is to shunt the cerebrospinal fluid (CSF) to another body

area. Synonym(s): water on the brain.

optic nerve. Transmits visual information from the retina to the brain.

spina bifida. Lack of closure in the vertebral column with protrusion of the

spinal cord through the defect, often in the lumbar sacral area. This condition
can be recognized by the presence of alpha-fetoproteins in the amniotic fluid and may present alone or in conjunction with other anomalies, and with or without hydrocephalus. Spina bifida is reported with a code from ICD-9-CM category 741, with a mandatory fifth digit specifying the location of the lesion.

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Anesthesia for intracranial procedures; subdural taps

Coding Tips
This code is used to indicate anesthesia at the time of spinal injection, drainage, or aspiration procedures represented by surgical codes 61000-61001, 61020, 61026, 61050, 61055, and 61070. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
61000, 61001, 61020, 61026, 61050, 61055, 61070

ICD-9-CM Diagnostic Codes
321.1 Meningitis in other fungal diseases — (Code first underlying disease: 110.0-118)
321.2 Meningitis due to viruses not elsewhere classified — (Code first underlying disease: 060.0-066.9)
321.3 Meningitis due to trypanosomiasis — (Code first underlying disease: 086.0-086.9)
321.4 Meningitis in sarcoidosis — (Code first underlying disease: 135)
321.8 Meningitis due to other nonbacterial organisms classified elsewhere — (Code first underlying disease)
324.0 Intracranial abscess
324.1 Intraspinal abscess
331.3 Communicating hydrocephalus — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
331.4 Obstructive hydrocephalus — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
331.5 Idiopathic normal pressure hydrocephalus [INPH] — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
349.81 Cerebrospinal fluid rhinorrhea
368.2 Diplopia
722.71 Intervertebral cervical disc disorder with myelopathy, cervical region
723.0 Spinal stenosis in cervical region
723.1 Cervicalgia
723.3 Cervicobrachial syndrome (diffuse)
741.01 Spina bifida with hydrocephalus, cervical region
742.3 Congenital hydrocephalus
771.2 Other congenital infection specific to the perinatal period — (Use additional code(s) to further specify condition)

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<th>Coding and Payment Guide for Anesthesia Services</th>
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<td>Syncope and collapse</td>
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<td>780.4</td>
<td>Dizziness and giddiness</td>
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<td>780.61</td>
<td>Fever presenting with conditions classified elsewhere — (Code first underlying condition when associated fever is present: 204-208, 282.60-282.69, 288.00-288.09)</td>
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<td>Postprocedural fever</td>
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<td>Intracranial injury of other and unspecified nature, without mention of open intracranial wound, unspecified state of consciousness</td>
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<td>907.0</td>
<td>Late effect of intracranial injury without mention of skull fracture</td>
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<tr>
<td>996.2</td>
<td>Mechanical complication of nervous system device, implant, and graft</td>
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<td>996.63</td>
<td>Infection and inflammatory reaction due to nervous system device, implant, and graft — (Use additional code to identify specified infections)</td>
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<td>997.01</td>
<td>Central nervous system complication — (Use additional code to identify complications)</td>
</tr>
<tr>
<td>945.2</td>
<td>Presence of cerebrospinal fluid drainage device</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for intracranial procedures; burr holes, including ventriculography

Coding Tips
This code represents anesthesia services provided during such surgical procedures as twist drill, burr hole(s) or trephine (surgical codes 61105, 61107, 61108, 61120, 61140, 61150, 61151, 61154, 61156, 61210, 61250, and 61253) some stereotaxis procedures (61735, 61770) placement of intracranial neurostimulators (61850) or stereotactic placement of infusion catheters in the brain (0169T). See the Surgical to Anesthesia Crosswalk for specific surgical codes that are associated with this anesthesia service. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
burr. Specialized surgical drill used to shape or make holes in bones or gain access into the cranium. Use of a burr has no bearing on coding, as this is a surgeon's instrument.
evacuation. Removal or purging of waste material.
hematoma. Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.
infratentorial. Located below or beneath the tentorium of the cerebellum, which is the dura mater supporting the occipital lobes and covering the cerebellum.
meninges. Tough membranous protectors of the central nervous system that cover the brain and spinal cord comprising three layers: the dura mater, arachnoid mater, and pia mater.
stereotaxis. Three-dimensional method for precisely locating structures.
subdural. Space between the dura matter and arachnoid in the brain.
trephine (bone). Specialized round saw for cutting circular holes in bone, especially the skull.

Surgical to Anesthesia Code Crosswalk

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<th>Base Unit</th>
<th>Work Value</th>
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00215
00215  Anesthesia for intracranial procedures; cranioplasty or elevation of depressed skull fracture, extradural (simple or compound)

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers. Fractures may be defined as closed or open. A closed fracture is one in which the skin is intact at the site of the fracture. An open fracture is one in which there is a wound communicating from the skin surface to the fracture site. Open fractures may occur when an external object penetrates the skin to fracture the bone or when a bone or bone fragment penetrates the skin from within. Skull fracture (800-804) is a fracture of any of the bones of the cranial vault and facial bones, including the nasal bones (category 802).

Terms To Know
- **cerebellum.** Portion of the brain in the rear cranial fossa behind the brain stem responsible for movement coordination.
- **cerebrum.** Primary portion of the brain in the upper part of the cranium that is the largest part of the central nervous system. It is divided into two hemispheres connected by the corpus callosum with the hemispheres divided into the frontal, parietal, temporal, occipital, and insular lobes. The functions of the cerebrum include intelligence, personality, motor function, planning and organization, and interpretation of sensory input.
- **depressed skull fracture.** Skull bones that are broken and driven inward from a forceful blow.
- **dura mater.** Outermost, hard, fibrous layer or membrane that surrounds the brain and spinal cord.
- **extradural.** Located outside of the dura mater.
- **hematoma.** Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.
- **hemorrhage.** Internal or external bleeding with loss of significant amounts of blood.
- **subarachnoid.** Located below the arachnoid meningeal layer.
- **subdural.** Space between the dura mater and arachnoid in the brain.

Surgical to Anesthesia Code Crosswalk
62000, 62005, 62116, 62120, 62140, 62141, 62146, 62147

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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<th>Procedure Codes</th>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00216

00216  Anesthesia for intracranial procedures; vascular procedures

**Coding Tips**

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers. This code represents anesthesia performed during vascular procedures of the head including but not limited to the treatment of arteriovenous malformations and aneurysms.

**Surgical to Anesthesia Code Crosswalk**

61700, 61702, 61703, 61705, 61708, 61710, 61711

61613, 61680, 61682, 61684, 61686, 61690, 61692, 61697, 61698

**ICD-9-CM Diagnostic Codes**

228.02  Hemangioma of intracranial structures

430  Subarachnoid hemorrhage — (Use additional code to identify presence of hypertension)

433.10  Occlusion and stenosis of carotid artery without mention of cerebral infarction — (Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility: V45.88)

433.20  Occlusion and stenosis of vertebral artery without mention of cerebral infarction — (Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility: V45.88)

433.30  Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction — (Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility: V45.88)

433.80  Occlusion and stenosis of other specified precerebral artery without mention of cerebral infarction — (Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility: V45.88)

437.0  Cerebral atherosclerosis — (Use additional code to identify presence of hypertension)

437.3  Cerebral aneurysm, nonruptured — (Use additional code to identify presence of hypertension)

437.8  Other ill-defined cerebrovascular disease — (Use additional code to identify presence of hypertension)

440.8  Atherosclerosis of other specified arteries

440.9  Generalized and unspecified atherosclerosis

442.81  Aneurysm of artery of neck

442.9  Other aneurysm of unspecified site

443.21  Dissection of carotid artery

444.81  Embolism and thrombosis of iliac artery

447.1  Stricture of artery

747.81  Congenital anomaly of cerebrovascular system

853.00  Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, unspecified state of consciousness

900.01  Common carotid artery injury

900.82  Injury to multiple blood vessels of head and neck

900.89  Injury to other specified blood vessels of head and neck

900.9  Injury to unspecified blood vessel of head and neck

908.3  Late effect of injury to blood vessel of head, neck, and extremities

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4, 10.4; 100-4, 10.5; 100-4, 250.3; 100-4, 250.3.1; 100-4, 12, 140.1; 100-4, 12, 140.3; 100-4, 12, 140.3.4; 100-4, 12, 140.4; 100-4, 12, 140.4.3; 100-4, 12, 140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<th>Procedure Codes</th>
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<td>00216</td>
<td>Anesthesia for intracranial procedures; vascular procedures</td>
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<td>(Use additional code to identify presence of hypertension)</td>
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<tr>
<td>433.30</td>
<td>Occlusion and stenosis of multiple and bilateral precerebral arteries without mention of cerebral infarction; (Use additional code, if applicable, to identify status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility: V45.88)</td>
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<tr>
<td>433.80</td>
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</tr>
<tr>
<td>437.0</td>
<td>Cerebral atherosclerosis; (Use additional code to identify presence of hypertension)</td>
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<tr>
<td>437.3</td>
<td>Cerebral aneurysm, nonruptured; (Use additional code to identify presence of hypertension)</td>
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<tr>
<td>437.8</td>
<td>Other ill-defined cerebrovascular disease; (Use additional code to identify presence of hypertension)</td>
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<tr>
<td>440.8</td>
<td>Atherosclerosis of other specified arteries</td>
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<tr>
<td>440.9</td>
<td>Generalized and unspecified atherosclerosis</td>
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00218

Anesthesia for intracranial procedures; procedures in sitting position

Coding Tips

Code 00218 can be used for any intracranial procedures performed by the surgeon as long as the patient is in the sitting position. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.
cerebellum. Portion of the brain in the rear cranial fossa behind the brain stem responsible for movement coordination.
cerebrum. Primary portion of the brain in the upper part of the cranium that is the largest part of the central nervous system. It is divided into two hemispheres connected by the corpus callosum with the hemispheres divided into the frontal, parietal, temporal, occipital, and insular lobes. The functions of the cerebrum include intelligence, personality, motor function, planning and organization, and interpretation of sensory input.
cranial fossae. Three fossae (anterior, middle, and posterior) that form the floor of the cranial cavity (on the superior aspect of the base of the skull) and that provide a surface to support the various lobes of the brain.
cranial nerve. Twelve paired bundles of nerves connected to the brain that control ocular, auditory, and nasal senses; facial muscles; and oral and throat muscles.
craniotomy. Surgical incision made into the cranium or skull for a number of surgical reasons (e.g., decompression, implantation of electrode array, excision, etc.).
meninges. Tough membranous protectors of the central nervous system that cover the brain and spinal cord comprising three layers: the dura mater, arachnoid mater, and pia mater.
syringomyelia. Progressive condition that may be from developmental origin or caused by trauma, tumor, hemorrhage, or infarction. An abnormal cavity (syrinx) forms in the spinal cord and enlarges over time, resulting in symptoms of muscle weakness; stiffness in the back, shoulders, arms, or legs; atrophy; headaches; dissociated memory loss; loss of sensory ability to feel pain; and extremes of hot or cold temperatures.

Surgical to Anesthesia Code Crosswalk

61305, 61314, 61315, 61321, 61343, 61345, 61458, 61518, 61520, 61521, 61522, 61524, 61530

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
772.12 Intraventricular hemorrhage, Grade II — (Use additional code(s) to further specify condition)
772.13 Intraventricular hemorrhage, Grade III — (Use additional code(s) to further specify condition)
772.14 Intraventricular hemorrhage, Grade IV — (Use additional code(s) to further specify condition)
905.0 Late effect of fracture of skull and face bones
907.0 Late effect of intracranial injury without mention of skull fracture
996.2 Mechanical complication of nervous system device, implant, and graft
996.63 Infection and inflammatory reaction due to nervous system device, implant, and graft — (Use additional code to identify specified infections)
996.75 Other complications due to nervous system device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)
V3.01 Fitting and adjustment of cerebral ventricular (communicating) shunt

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3

Coding and Payment Guide for Anesthesia Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>00220</td>
<td>Anesthesia for intracranial procedures; cerebrospinal fluid shunting procedures</td>
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**Coding Tips**
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**
**Hydrocephalus**: Abnormal buildup of cerebrospinal fluid in the brain, causing dilation of the ventricles. Hydrocephalus is most often the result of obstructed cerebrospinal fluid pathways either congenital or acquired. The primary treatment method is to shunt the cerebrospinal fluid (CSF) to another body area. A **shunt** is a surgically created passage between blood vessels or other natural passages, such as an arteriovenous anastomosis, to divert or bypass blood flow from the normal channel.

**Surgical to Anesthesia Code Crosswalk**
62180, 62190, 62192, 62194, 62200, 62201, 62220, 62223, 62225, 62230, 62252, 62256, 62258

**ICD-9-CM Diagnostic Codes**
191.3 Malignant neoplasm of ventricles of brain
191.6 Malignant neoplasm of cerebellum NOS
198.3 Secondary malignant neoplasm of brain and spinal cord
225.0 Benign neoplasm of brain
225.2 Benign neoplasm of cerebral meninges
225.8 Benign neoplasm of other specified sites of nervous system
225.9 Benign neoplasm of nervous system, part unspecified
237.5 Neoplasm of uncertain behavior of brain and spinal cord
239.6 Neoplasm of unspecified nature of brain
313.1 Communicating hydrocephalus — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
313.4 Obstructive hydrocephalus — (Use additional code, where applicable, to identify dementia: 294.10, 294.11)
348.0 Cerebral cysts
348.2 Benign intracranial hypertension
741.01 Spina bifida with hydrocephalus, cervical region
741.03 Spina bifida with hydrocephalus, lumbar region
742.3 Congenital hydrocephalus
772.10 Intraventricular hemorrhage, unspecified grade — (Use additional code(s) to further specify condition)
772.11 Intraventricular hemorrhage, Grade I — (Use additional code(s) to further specify condition)

**CCI Version 20.0**

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Base Unit** | **Work Value** | **Non-Fac PE** | **Fac PE** | **Malpractice** | **Non-Fac Total** | **Fac Total**
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00220 | 10.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00
00222

00222  Anesthesia for intracranial procedures; electrocoagulation of intracranial nerve

Coding Tips

Code 00222 represent anesthesia provided during electrocoagulation of intracranial nerve procedures such as those represented by surgical codes 61790-61791. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

cranial nerve. Twelve paired bundles of nerves connected to the brain that control ocular, auditory, and nasal senses; facial muscles; and oral and throat muscles.

electrocautery. Division or cutting of tissue using high-frequency electrical current to produce heat, which destroys cells.
intracranial. Within the cranium (skull).
malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other areas in the body.

trigeminal neuralgia. Pain in the trigeminal nerve or branch.

Surgical to Anesthesia Code Crosswalk

61790, 61791

ICD-9-CM Diagnostic Codes

192.0  Malignant neoplasm of cranial nerves
195.0  Malignant neoplasm of head, face, and neck
198.4  Secondary malignant neoplasm of other parts of nervous system
350.1  Trigeminal neuralgia
350.2  Atypical face pain
350.8  Other specified trigeminal nerve disorders

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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</table>

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Surgical to Anesthesia Code Crosswalk

Located in the back part or caudal end of the body. Anesthesia for lesion removal is usually performed by the surgeon. If because of the size of the lesion, age or mental status of the patient, or if other conditions are present, the medical necessity of an anesthesiologist may be supported. Include any appropriate ICD-9-CM codes necessary or attach report. The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

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Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; not otherwise specified, age 1 year or older

Coding Tips
When the patient is younger than one year of age, and the procedure is performed on the larynx or trachea, see code 00326. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **epiglottis**: Lid-like cartilaginous tissue that covers the entrance to the larynx and blocks food from entering the trachea.
- **esophagus**: Muscular tube that carries swallowed liquids and foods from the pharynx to the stomach.
- **goiter**: Abnormal enlargement of the thyroid gland commonly caused by a deficiency of dietary iodine.
- **larynx**: Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism.
- **lymphadenitis**: Inflammation of the lymph nodes.
- **lymphatic system**: Lymphatic capillaries, vessels, lymph nodes, spleen, thymus gland, and bone marrow.
- **thyroid**: Endocrine gland located in the front of the lower neck composed of two lobes on either side of the trachea, responsible for secreting and storing the thyroid hormones that regulate metabolism.
- **trachea**: Tube descending from the larynx and branching into the right and left main bronchi.

Surgical to Anesthesia Code Crosswalk

<table>
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<th>Procedure Code</th>
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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
Anesthesia for all procedures on esophagus, thyroid, larynx, trachea and lymphatic system of neck; needle biopsy of thyroid

Coding Tips
For procedures performed on the cervical spine and spinal cord, see codes 00600, 00604, and 00670. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
epiglottis. Lid-like cartilaginous tissue that covers the entrance to the larynx and blocks food from entering the trachea.
esophagus. Muscular tube that carries swallowed liquids and foods from the pharynx to the stomach.
goiter. Abnormal enlargement of the thyroid gland commonly caused by a deficiency of dietary iodine, reported with ICD-9-CM code 240.9 or ICD-10-CM code E40.9.
larynx. Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism.
lymphadenitis. Inflammation of the lymph nodes.
lymphatic system. Lymphatic capillaries, vessels, lymph nodes, spleen, thymus gland, and bone marrow.
thyroid. Endocrine gland located in the front of the lower neck composed of two lobes on either side of the trachea, responsible for secreting and storing the thyroid hormones that regulate metabolism.
trachea. Tube descending from the larynx and branching into the right and left main bronchi.

Surgical to Anesthesia Code Crosswalk
60001, 60100, 60300

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,4,250.3.3; 100-4,12,140.3.4; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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00326

Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age

Coding Tips
Do not report code 99100 in addition to code 00326. When the patient is older than 1 year of age, see code 00320. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
asphyxia. Insufficient intake of oxygen, resulting in pathological changes brought on by a lack of oxygen perfusion to the tissues or excessive carbon dioxide in the blood. Correct code assignment is dependent upon a number of factors including age and cause.
larynx. Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism.
trachea. Tube descending from the larynx and branching into the right and left main bronchi.
tracheostomy. Formation of a tracheal opening on the neck surface with tube insertion to allow for respiration in cases of obstruction or decreased patency. A tracheostomy may be planned or performed on an emergency basis for temporary or long-term use.

Surgical to Anesthesia Code Crosswalk
21495, 31300, 31320, 31360, 31367, 31370, 31375, 31380, 31382, 31400, 31420, 31502, 31505, 31510, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31545, 31546, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579, 31580, 31582, 31584, 31587, 31588, 31590, 31595, 31600, 31601, 31603, 31605, 31610, 31611, 31612, 31613, 31614, 31615, 31622, 31623, 31624, 31625, 31626, 31628, 31629, 31630, 31631, 31635, 31636, 31638, 31640, 31641, 31643, 31645, 31646, 31647, 31648, 31660, 31661, 31715, 31730, 31750, 31755, 31760, 31780, 31781, 31785, 31786, 31800, 31805, 31820, 31825, 32701, 52340, 52341

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,250.3.2

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**00350**

**CPT Coding Tips**

Anesthesia for procedures on major vessels of neck; not otherwise specified

**Coding Tips**

This code should be used to report anesthesia during a procedure on a major vessel of the neck, such as the internal or external carotid artery or the jugular vein. Code 00350 should not be reported for arteriography. When anesthesia is performed during an arteriography, code 01916 should be assigned. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- Apraxia: Impaired sequencing of motor skills. Apraxia can be used to describe a variety of symptoms, from an awkward gait to anomalous speech.
- Arteriography: Radiologic study of an artery upon injection of dye.
- Dysphagia: Difficulty and pain upon swallowing.
- Occlusion: Constriction, closure, or blockage of a passage.
- Stenosis: Narrowing or constriction of a passage.

**Surgical to Anesthesia Code Crosswalk**

0075T, 0266T, 0267T, 0269T, 0270T, 0271T, 31365, 31368, 31390, 31395, 33889, 33891, 34001, 34471, 35001, 35002, 35005, 35180, 35188, 35201, 35231, 35261, 35301, 35305, 35306, 35507, 35508, 35509, 35510, 35511, 35512, 35515, 35601, 35606, 35612, 35642, 35645, 35691, 35693, 35694, 35695, 35701, 35761, 35800, 35875, 35876, 35901, 36100, 36215, 36216, 36217, 36222, 36223, 36224, 36225, 36266, 37215, 37216, 60605

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-4,12,140.4; 100-4,12,140.4,1; 100-4,12,140.4,2; 100-4,12,140.4,3; 100-4,12,140.4,4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for procedures on major vessels of neck; simple ligation

**Coding Tips**
Code 00352 is used when the surgeon performs a simple ligation of the vessels of the neck. See surgery codes 37565, 37600, 37605, 37606, 37607, 37609, and 37615. This code should not be reported for arteriography. When anesthesia is performed during an arteriography, code 01916 should be assigned.

**Terms To Know**
ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.

**Surgical to Anesthesia Code Crosswalk**
37565, 37600, 37605, 37606, 37607, 37609, 37615

**ICD-9-CM Diagnostic Codes**

- Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified — (Use additional code to identify manifestation: 443.81, 785.4) (Use additional code to identify any associated insulin use: V58.67)

- Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4) (Use additional code to identify any associated insulin use: V58.67)

- Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

- Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

- Essential hypertension, malignant

- Essential hypertension, benign

- Unspecified essential hypertension

- Unspecified transient cerebral ischemia — (Use additional code to identify presence of hypertension)

- Aneurysm of artery of neck

- Dissection of carotid artery

- Giant cell arteritis

- Stricture of artery

- Rupture of artery

- Unspecified arteritis

- Other specified disorders of arteries and arterioles

- Other disease of pharynx or nasopharynx — (Use additional code to identify infectious organism)

- Congenital anomaly of cerebrovascular system

- Syncope and collapse

- Dizziness and giddiness

- Headache

- Swelling, mass, or lump in head and neck

- Epistaxis

- Open wound of other and unspecified parts of neck, without mention of complication

- Injury to carotid artery, unspecified

- Common carotid artery injury

- External carotid artery injury

- Internal carotid artery injury

- Internal jugular vein injury

- Injury to multiple blood vessels of head and neck

- Injury to other specified blood vessels of head and neck

- Hemorrhage complicating a procedure

- Hematoma complicating a procedure

- Seroma complicating a procedure

- Accidental puncture or laceration during procedure

- Observation for other specified suspected conditions

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**Coding Tips**

Anesthesia for lesion removal is usually performed by the surgeon. If because of the size of the lesion, age or mental status of the patient, or if other conditions are present, the medical necessity of an anesthesiologist may be supported. Include any appropriate ICD-9-CM codes necessary or attach report. For reconstructive breast procedures, see code 00402. For radical procedures on the breast, see code 00404.

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

**Anterior.** Situated in the front area or toward the belly surface of the body. **Integumentary.** Skin system covering the body that includes the epidermis, dermis, hair, nails, and glands.

### Surgical to Anesthesia Code Crosswalk

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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00402

00402  Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; reconstructive procedures on breast (eg, reduction or augmentation mammoplasty, muscle flaps)

Coding Tips
For radical breast procedures, see code 00404. For radical breast procedures that include mammary node dissection, see 00406. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
augmentation. Add to or increase the substance of a body site, usually performed as plastic reconstructive measures. Augmentation may involve the use of an implant or prosthesis, especially within soft tissue or grafting procedures, such as bone tissue.
cosmetic. Superficial or external, having no medical necessity.
flap. Mass of flesh and skin partially excised from its location but retaining its blood supply that is moved to another site to repair adjacent or distant defects.
implant. Material or device inserted or placed within the body for therapeutic, reconstructive, or diagnostic purposes.
mammaplasty. Plastic or surgical repair of the breast.
reconstruction. Recreating, restoring, or rebuilding a body part or organ.

Surgical to Anesthesia Code Crosswalk
11970, 19316, 19318, 19324, 19325, 19328, 19330, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19368, 19369, 19370, 19371, 19380, 64774, S2066, S2067, S2068

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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00404-00406

00404  Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; radical or modified radical procedures on breast

00406  radical or modified radical procedures on breast with internal mammary node dissection

Coding Tips

For reconstructive breast procedures, see code 00402. Report 00404 when internal mammary dissection is not performed. If internal mammary node dissection is performed at the same setting, see code 00406.

Surgical to Anesthesia Code Crosswalk

19162, 19200, 19220, 19240, 19302, 19305, 19306, 19307, 64774

ICD-9-CM Diagnostic Codes

174.0  Malignant neoplasm of nipple and areola of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.1  Malignant neoplasm of central portion of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.2  Malignant neoplasm of upper-quadrant of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.3  Malignant neoplasm of lower-inner quadrant of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.4  Malignant neoplasm of upper-outer quadrant of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.5  Malignant neoplasm of lower-outer quadrant of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.6  Malignant neoplasm of axillary tail of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.7  Malignant neoplasm of other specified sites of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.8  Malignant neoplasm of central portion of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

174.9  Malignant neoplasm of other and unspecified sites of female breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

175.0  Malignant neoplasm of nipple and areola of male breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

175.9  Malignant neoplasm of other and unspecified sites of male breast — (Use additional code to identify estrogen receptor status: V86.0-V86.1)

196.3  Secondary and unspecified malignant neoplasm of lymph nodes of axilla and upper limb

198.81  Secondary malignant neoplasm of breast

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00410

00410 Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; electrical conversion of arrhythmias

Coding Tips
When monitored anesthesia care (MAC) is performed for surgical procedures on the skin that are normally performed under local anesthetic because of other indications (e.g., age of patient, mental status, or size of lesion), a report may be necessary.

Terms To Know
- arrhythmia. Irregular heartbeat.
- atrial fibrillation. Cardiac arrhythmia caused by small areas of muscle fibers becoming erratically and spontaneously activated through multiple circuits in uncoordinated phases of depolarization and repolarization. This causes the atria to quiver in a continuously erratic pattern instead of contracting in the regular rhythm. Report atrial fibrillation with ICD-9-CM code 427.31.
- atrial flutter. Form of cardiac arrhythmia in which the upper chambers (atria) of the heart experience well-organized but exceedingly rapid contractions. Many impulses begin and spread through the atria, but occur so rapidly that the atria cannot fully empty their contents into the ventricles of the heart. Report atrial flutter with ICD-9-CM code 427.32.
- tachycardia-bradycardia syndrome. Rapid action of the heart followed by protracted or transient stopping of the heart. Report this disorder with ICD-9-CM code 427.81. Synonym(s): sick sinus syndrome.
- ventricular tachycardia. Excessively rapid ventricular rhythm of the heart, usually more than 150 beats per minute, with an origin beat generated in the ventricle, commonly from atrioventricular dissociation.

Surgical to Anesthesia Code Crosswalk
64774, 92960

ICD-9-CM Diagnostic Codes
426.0 Atrioventricular block, complete
426.10 Unspecified atrioventricular block
426.11 First degree atrioventricular block
426.12 Mobitz (type) II atrioventricular block
426.13 Other second degree atrioventricular block
426.14 Left bundle branch hemiblock
426.15 Other left bundle branch block
426.2 Right bundle branch block
426.50 Unspecified bundle branch block
426.51 Right bundle branch block and left posterior fascicular block
426.52 Right bundle branch block and left anterior fascicular block
426.53 Other bilateral bundle branch block
426.54 Trifascicular block
426.6 Other heart block
426.7 Anomalous atrioventricular excitation
426.81 Lown-Ganong-Levine syndrome
426.89 Other specified conduction disorder
426.9 Unspecified conduction disorder
427.0 Paroxysmal supraventricular tachycardia
427.1 Paroxysmal ventricular tachycardia
427.2 Unspecified paroxysmal tachycardia
427.31 Atrial fibrillation
427.32 Atrial flutter
427.41 Ventricular fibrillation
427.42 Ventricular flutter
427.60 Unspecified premature beats
427.61 Supraventricular premature beats
427.69 Other premature beats
427.81 Sinus atrial node dysfunction
427.89 Other specified cardiac dysrhythmias
427.9 Unspecified cardiac dysrhythmia

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for procedures on clavicle and scapula; not otherwise specified

00450  Anesthesia for procedures on clavicle and scapula; not otherwise specified
00452  radical surgery
00454  biopsy of clavicle

Coding Tips
Code 00452 is reported when radical surgery is performed on the clavicle and scapula. When only a biopsy is performed, other than skin, report code 00454. When biopsy is of the skin, see code 00406. Code 00450 is reported when procedures not identified in code 00452 or 00454 are performed. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
bone marrow. Soft tissue found filling the cavities of bones. Red bone marrow is a hematopoietic tissue that manufactures various cellular components of blood, such as platelets and red and white blood cells. Yellow marrow consists mostly of fat cells and is found in the medullary cavities of large bones. It may be harvested and transplanted for its progenitor or stem cells in cases of leukemia and other diseases biopsied to help diagnose many diseases of the blood.
osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.
periosteum. Double-layered connective membrane on the outer surface of bone.
periostitis. Inflammation of the outer layers of bone.
radical. Extensive surgery.
scapula. Triangular bone commonly referred to as the shoulder blade.

Surgical to Anesthesia Code Crosswalk
11012, 11044, 20220, 20982, 23120, 23125, 23140, 23145, 23146, 23170, 23172, 23180, 23182, 23190, 23200, 23210, 23215, 23480, 23485, 23490, 23500, 23505, 23515, 23570, 23575, 23585

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.3.3; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for partial rib resection; not otherwise specified

Coding Tips
Report code 00472 when documentation indicates that the surgeon performed any type of thoracoplasty, including excision of some tumors and some forms of fracture treatment. Code 00474 is used to report anesthesia provided during extensive procedures on the chest such as excision of malignant tumors or correction of pectus excavatum. Anesthesia provided during other procedures not identified by these codes is reported with code 00470.

Terms To Know
congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
excision. Surgical removal of an organ or tissue.
pectus excavatum. Congenital abnormality of the anterior chest wall with depression of the sternum, sinking the appearance of the chest. This abnormality is reported with ICD-9-CM code 754.81. Synonym(s): funnel chest.
radical. Extensive surgery.
resection. Surgical removal of a part or all of an organ or body part.

Surgical to Anesthesia Code Crosswalk
0245T, 0246T, 0247T, 0248T, 11012, 11044, 19260, 19271, 20240, 20910, 21230, 21502, 21510, 21600, 21610, 21615, 21616, 21620, 21630, 21632, 21705, 21740, 21742, 21743, 21805, 21810, 21820, 21825, 32820, 32900, 32905, 32906

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3,2.2; 100-4,4,250.3,3.1; 100-4,4,12,140.1; 100-4,4,12,140.3; 100-4,4,12,140.3,3; 100-4,4,12,140.3,4; 100-4,4,12,140.4,1; 100-4,4,12,140.4,2; 100-4,4,12,140.4,3; 100-4,4,12,140.4,4

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Anesthesia for all procedures on esophagus

**Coding Tips**

Anesthesia performed for endoscopic procedures are usually performed under sedation by the surgeon. When the patient has a condition that warrants monitored anesthesia care (MAC) by an anesthesiologist, an additional report may be required. In these circumstances, also use the appropriate physical status and/or qualifying circumstances modifier if accepted by the third-party payer. Additional diagnoses supporting the need for the anesthesiologist’s presence should also be supplied.

**Surgical to Anesthesia Code Crosswalk**

43045, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43125, 43127, 43129, 43135, 43279, 43310, 43312, 43313, 43314, 43331, 43341, 43351, 43360, 43361, 43400, 43401, 43415, 43425, 43496, S2079

**ICD-9-CM Diagnostic Codes**

- Malignant neoplasm of cervical esophagus 150.0
- Malignant neoplasm of thoracic esophagus 150.1
- Malignant neoplasm of abdominal esophagus 150.2
- Malignant neoplasm of upper third of esophagus 150.3
- Malignant neoplasm of middle third of esophagus 150.4
- Malignant neoplasm of lower third of esophagus 150.5
- Malignant neoplasm of other specified part of esophagus 150.8
- Benign neoplasm of esophagus 211.0
- Carcinoma in situ of esophagus 230.1
- Esophageal varices with bleeding 456.0
- Esophageal varices without mention of bleeding 456.1
- Esophageal varices with bleeding in diseases classified elsewhere — (Code first underlying disease: 571.0-571.9, 572.3) 456.20
- Esophageal varices without mention of bleeding in diseases classified elsewhere — (Code first underlying disease: 571.0-571.9, 572.3) 456.21
- Reflux esophagitis — (Use additional E code to identify cause, if induced by chemical) 530.11
- Acute esophagitis — (Use additional E code to identify cause, if induced by chemical) 530.12
- Other esophagitis — (Use additional E code to identify cause, if induced by chemical) 530.19
- Ulcer of esophagus with bleeding — (Use additional E code to identify cause, if induced by chemical or drug) 530.21
- Stricture and stenosis of esophagus 530.3
- Perforation of esophagus 530.4
- Dyskinesia of esophagus 530.5
- Diverticulum of esophagus, acquired 530.6
- Gastroesophageal laceration-hemorrhage syndrome 530.7
- Esophageal reflux 530.81
- Esophageal hemorrhage 530.82
- Esophageal leukoplakia 530.83
- Tracheoesophageal fistula 530.84
- Barrett’s esophagus 530.85
- Congenital tracheoesophageal fistula, esophageal atresia and stenosis 750.3
- Congenital hiatus hernia 750.6
- Dysphagia, pharyngoesophageal phase 787.24
- Esophagus injury without mention of open wound into cavity 862.22
- Esophagus injury with open wound into cavity 862.32
- Late effect of burns of other specified sites 906.8
- Foreign body in esophagus 935.1
- Burn of esophagus 947.2

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Procedure Codes**

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00520

00520  Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified

Coding Tips

This code is appropriate to report anesthesia provided during a bronchoscopy. Anesthesia performed for endoscopic procedures are usually performed under sedation by the surgeon. When the patient has a condition that warrants monitored anesthesia care (MAC) by an anesthesiologist, an additional report may be required. In these circumstances, also use the appropriate physical status and/or qualifying circumstances modifier if accepted by the third-party payer. Additional diagnoses supporting the anesthesiologist’s presence should also be reported. Report anesthesia during a needle biopsy of pleura using code 00522. Report anesthesia during a pneumocentesis with code 00524. To report anesthesia during a mediastinoscopy and diagnostic thoracoscopy, see codes 00528-00529.

Terms To Know

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

bronchoscopy. Endoscopic procedure used for the diagnosis, inspection, and treatment of the tracheobronchial tree. The diagnostic procedure alone is reported with CPT code 31622 and includes the use of fluoroscopic guidance. Report other bronchoscopy services with CPT codes 31623-31661.

centesis. Puncture, as with a needle, trocar, or aspirator, often done for withdrawing fluid from a cavity.

fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.

pleura. Thin membrane covering the lungs and lining the inside of the chest wall.

pneum(o)-. Relating to respiration, air, the lungs.

Surgical to Anesthesia Code Crosswalk

0251T, 0276T, 0277T, 0340T, 20982, 21800, 21820, 31622, 31623, 31624, 31625, 31626, 31627, 31628, 31629, 31630, 31631, 31632, 31633, 31634, 31635, 31636, 31637, 31640, 31641, 31643, 31645, 31646, 31647, 31648, 31656, 31660, 31661, 31710, 31717, 31720, 31725, 32002, 32005, 32019, 32020, 32420, 32421, 32422, 32550, 32551, 32552, 32553, 32554, 32555, 32556, 32557, 32560, 32561, 32562, 32701, 32997, 32998, 33010, 33011, 33234, 33235, 43450, 43453, 43456, 43458, 43460, 96440

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

Fac TotalNon-Fac TotalMalpracticeFac PENon-Fac PEWork ValueBase Unit

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Anesthesia for closed chest procedures; needle biopsy of pleura

Coding Tips

To report anesthesia during bronchoscopy, see code 00520. To report anesthesia during a mediastinoscopy, see codes 00528-00529.

Terms To Know

- biopsy: Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
- centesis: Puncture.
- pleura: Thin membrane covering the lungs and lining the inside of the chest wall.
- pneum(o)-: Relating to respiration, air, the lungs.

Surgical to Anesthesia Code Crosswalk

0340T, 32000, 32400, 32405, 32420, 32421, 32422, 32554, 32555, 32960

ICD-9-CM Diagnostic Codes

162.2 Malignant neoplasm of main bronchus
162.3 Malignant neoplasm of upper lobe, bronchus, or lung
162.4 Malignant neoplasm of middle lobe, bronchus, or lung
162.5 Malignant neoplasm of lower lobe, bronchus, or lung
163.0 Malignant neoplasm of parietal pleura
163.1 Malignant neoplasm of visceral pleura
164.2 Malignant neoplasm of anterior mediastinum
164.3 Malignant neoplasm of posterior mediastinum
164.8 Malignant neoplasm of other parts of mediastinum
176.4 Kaposi's sarcoma of lung
195.1 Malignant neoplasm of thorax
197.0 Secondary malignant neoplasm of lung
197.1 Secondary malignant neoplasm of mediastinum
197.2 Secondary malignant neoplasm of pleura
212.3 Benign neoplasm of bronchus and lung
212.4 Benign neoplasm of pleura
212.5 Benign neoplasm of mediastinum
215.5 Other benign neoplasm of connective and other soft tissue of abdomen
231.2 Carcinoma in situ of bronchus and lung
231.8 Carcinoma in situ of other specified parts of respiratory system
235.7 Neoplasm of uncertain behavior of trachea, bronchus, and lung
235.8 Neoplasm of uncertain behavior of pleura, thymus, and mediastinum
235.9 Neoplasm of uncertain behavior of other and unspecified respiratory organs

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00528-00529

00528  Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopic not utilizing 1 lung ventilation

00529  mediastinoscopy and diagnostic thoracoscopic utilizing 1 lung ventilation

Coding Tips
These codes are used to report anesthesia provided during thoracoscopy or mediastinoscopy procedures represented by surgical codes 32601-32606, 32650-32665, 33203, and 39400. Carefully examine the medical record documentation to determine the presence of one lung ventilation (00529) or without one lung ventilation (00528). For tracheobronchial reconstruction, see code 00539.

Terms To Know

diagnostic. Examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.

lymph nodes. Bean-shaped structures along the lymphatic vessels that intercept and destroy foreign materials in the tissue and bloodstream.

mediastinum. Collection of organs and tissues that separate the pleural sacs. Located between the sternum and spine above the diaphragm, it contains the heart and great vessels, trachea and bronchi, esophagus, thymus, lymph nodes, and nerves.

pleural effusion. Collection of lymph and other fluid within the pleural space.

thoraco-. Relating to the chest.

thymus. Lymphoid organ located in the front of the upper mediastinum, composed of two symmetrical pyramid-shaped lobes, that is the site where T-lymphocytes are produced.

Surgical to Anesthesia Code Crosswalk
0340T, 32601, 32602, 32603, 32604, 32605, 32606, 32607, 32608, 32609, 33203, and 39400

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,4,1,2,140.1; 100-4,4,12,140.2; 100-4,4,12,140.3; 100-4,4,12,140.3.4; 100-4,4,12,140.4; 100-4,4,12,140.4.4

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CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**Coding and Payment Guide for Anesthesia Services**

**Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>00530</td>
<td>Anesthesia for permanent transvenous pacemaker insertion</td>
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</table>

**Coding Tips**

Report anesthesia during transvenous insertion or replacement of pacing cardioverter-defibrillator with code 00534. General or monitored anesthesia will be reimbursed by Medicare when the medical record indicates a diagnosis of other hyperalimentation (278.8), intermediate coronary syndrome (411.1), pulmonary valve disorders (424.3), and heart failure (428.0-428.9). Additionally, Medicare will cover when documentation is present that the patient is uncontrollable under local anesthesia, is disoriented, or has mental confusion.

**Terms To Know**

- **insertion**: Placement or implantation into a body part.
- **pacemaker**: Implantable cardiac device that controls the heart's rhythm and maintains regular beats by artificial electric discharges. This device consists of the pulse generator with a battery and the electrodes, or leads, which are placed in single or dual chambers of the heart, usually transvenously.

**Surgical to Anesthesia Code Crosswalk**

- 0302T, 0303T, 0320T, 0325T, 33206, 33207, 33208, 33210, 33211, 33214, 33215, 33216, 33217, 33218, 33220, 33224, 33226

**ICD-9-CM Diagnostic Codes**

- 337.00 Idiopathic peripheral autonomic neuropathy, unspecified
- 337.01 Carotid sinus syndrome
- 426.0 Atrioventricular block, complete
- 426.10 Unspecified atrioventricular block
- 426.11 First degree atrioventricular block
- 426.12 Mobitz (type) II atrioventricular block
- 426.13 Other second degree atrioventricular block
- 426.6 Other heart block
- 426.7 Anomalous atrioventricular excitation
- 426.9 Unspecified conduction disorder
- 427.0 Paroxysmal supraventricular tachycardia
- 427.31 Atrial fibrillation
- 427.81 Sinoatrial node dysfunction
- 427.89 Other specified cardiac dysrhythmias
- 427.9 Unspecified cardiac dysrhythmia
- 746.86 Congenital heart block
- 996.01 Mechanical complication due to cardiac pacemaker (electrode)
- 996.04 Mechanical complication due to automatic implantable cardiac defibrillator
- 996.09 Mechanical complication of cardiac device, implant, and graft, other
- 996.61 Infection and inflammatory reaction due to cardiac device, implant, and graft — (Use additional code to identify specified infections)

### CPT Codes

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<td>997.1</td>
<td>Cardiac complications — (Use additional code to identify complications)</td>
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<td>Infected postoperative seroma — (Use additional code to identify organism)</td>
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<td>998.83</td>
<td>Non-healing surgical wound</td>
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<td>998.89</td>
<td>Other specified complications</td>
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<td>V45.01</td>
<td>Cardiac pacemaker in situ</td>
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<td>V45.09</td>
<td>Other specified cardiac device in situ</td>
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<td>V53.31</td>
<td>Fitting and adjustment of cardiac pacemaker</td>
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<td>V53.32</td>
<td>Fitting and adjustment of automatic implantable cardiac defibrillator</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

- 100-3, 100-3, 1.10.6; 100-3, 10.6; 100-4, 4, 10.4; 100-4, 4, 10.5; 100-4, 4, 250.3.2; 100-4, 4, 250.3.3.1; 100-4, 12, 140.1; 100-4, 12, 140.3; 100-4, 12, 140.3.3; 100-4, 12, 140.3.4; 100-4, 12, 140.4.1; 100-4, 12, 140.4.2; 100-4, 12, 140.4.3; 100-4, 12, 140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for access to central venous circulation

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **central venous catheter.** Catheter positioned in the superior vena cava or right atrium and introduced through a large vein, such as the jugular or subclavian, and used to measure venous pressure or administer fluids or medication.
- **intra-arterial infusion pump.** Implantable device consisting of a reservoir, or pump, that contains the drug to be administered. It is connected to a catheter that terminates in a specific artery. The pump delivers a measured amount of medication, such as a chemotherapeutic agent, directly into the arterial system through injection over a period of time.
- **venous.** Relating to the veins.

Surgical to Anesthesia Code Crosswalk
36011, 36012, 36481, 36500, 36510, 36530, 36531, 36532, 36533, 36534, 36535, 36536, 36537, 36561, 37619

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator

Coding Tips
When the procedure is performed via a transthoracic approach, see code 00560. Report code 00530 for anesthesia provided during transvenous placement of a permanent pacemaker.

Terms To Know
- cardioverter-defibrillator: Device that uses both low energy cardioversion or defibrillating shocks and antitachycardia pacing to treat ventricular tachycardia or ventricular fibrillation.
- insertion: Placement or implantation into a body part.
- replacement: Insertion of new tissue or material in place of old one.

Surgical to Anesthesia Code Crosswalk
0317T, 0318T, 0321T, 0322T, 0323T, 0324T, 0325T, 33215, 33216, 33217, 33218, 33220, 33224, 33244, 33249, G0448

ICD-9-CM Diagnostic Codes
427.0 Paroxysmal supraventricular tachycardia
427.1 Paroxysmal ventricular tachycardia
427.41 Ventricular fibrillation
427.42 Ventricular flutter
427.5 Cardiac arrest
427.89 Other specified cardiac dysrhythmias
996.01 Mechanical complication due to cardiac pacemaker (electrode)
996.04 Mechanical complication due to automatic implantable cardiac defibrillator
996.09 Mechanical complication of cardiac device, implant, and graft, other
996.61 Infection and inflammatory reaction due to cardiac device, implant, and graft — (Use additional code to identify specified infections)
996.72 Other complications due to other cardiac device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)
998.51 Infected postoperative seroma — (Use additional code to identify organism)
998.59 Other postoperative infection — (Use additional code to identify infection)
998.6 Persistent postoperative fistula, not elsewhere classified
998.83 Non-healing surgical wound
998.89 Other specified complications
V45.01 Cardiac pacemaker in situ
V45.02 Automatic implantable cardiac defibrillator in situ
V53.32 Fitting and adjustment of automatic implantable cardiac defibrillator
V53.39 Fitting and adjustment of other cardiac device

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-3,1.10.6; 100-3,10.6; 100-4,10.4; 100-4,4.10; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,4,250.3.4; 100-4,4,4.1; 100-4,4,4.2; 100-4,4,4.3; 100-4,4,4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **electrophysiologic studies.** Electrical stimulation and monitoring to diagnose heart conduction abnormalities that predispose patients to bradyarrhythmias and to determine a patient's chance for developing ventricular and supraventricular tachyarrhythmias.
- **radiofrequency ablation.** To destroy by electromagnetic wave frequencies.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes

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<td>Cardiovascular malfunction arising from mental factors</td>
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<td>426.0</td>
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<td>First degree atrioventricular block</td>
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<td>Sinoatrial node dysfunction</td>
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<td>427.89</td>
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<td>Dizziness and giddiness</td>
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<td>996.72</td>
<td>Other complications due to other cardiac device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)</td>
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<table>
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<tr>
<th>Procedure Codes</th>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4,4,10.4; 100-4,4,250.3.2

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for tracheobronchial reconstruction

Coding Tips
Report code 00548 for anesthesia during intrathoracic procedures on trachea and bronchi. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
31760, 31766, 31770, 31780, 31781, 32442, 32486

ICD-9-CM Diagnostic Codes
162.0 Malignant neoplasm of trachea
162.2 Malignant neoplasm of main bronchus
162.3 Malignant neoplasm of upper lobe, bronchus, or lung
162.4 Malignant neoplasm of middle lobe, bronchus, or lung
162.5 Malignant neoplasm of lower lobe, bronchus, or lung
162.8 Malignant neoplasm of other parts of bronchus or lung
162.9 Malignant neoplasm of bronchus and lung, unspecified site
171.4 Malignant neoplasm of connective and other soft tissue of thorax
197.0 Secondary malignant neoplasm of lung
197.1 Secondary malignant neoplasm of mediastinum
197.3 Secondary malignant neoplasm of other respiratory organs
209.21 Malignant carcinoid tumor of the bronchus and lung — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03)(Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)
209.61 Benign carcinoid tumor of the bronchus and lung — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03)(Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)
212.2 Benign neoplasm of trachea
212.3 Benign neoplasm of bronchus and lung
231.1 Carcinoma in situ of trachea
231.2 Carcinoma in situ of bronchus and lung
513.0 Abscess of lung — (Use additional code to identify infectious organism)
514 Pulmonary congestion and hypostasis — (Use additional code to identify infectious organism)
515 Postinflammatory pulmonary fibrosis — (Use additional code to identify infectious organism)

IOM References
100-4.4,10.4; 100-4.4,250.3.2

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CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified

Coding Tips
Code 00540 is appropriate when bilateral lung ventilation is provided. If one lung ventilation is performed, report code 00541. For anesthesia for closed chest procedures, see 00520, 00522-00524, and 00528-00529. Anesthesia services for procedures on the thoracic spine and spinal cord via an anterior transthoracic approach should be reported using code 00625 or 00626.

Terms To Know
- **diaphragm**: Muscular wall separating the thorax and its structures from the abdomen.
- **esophagus**: Muscular tube that carries swallowed liquids and foods from the pharynx to the stomach.
- **lymph nodes**: Bean-shaped structures along the lymphatic vessels that intercept and destroy foreign materials in the tissue and bloodstream.
- **mediastinum**: Collection of organs and tissues that separate the pleural sacs. Located between the sternum and spine above the diaphragm, it contains the heart and great vessels, trachea and bronchi, esophagus, thymus, lymph nodes, and nerves.
- **pleura**: Thin membrane covering the lungs and lining the inside of the chest wall.
- **thoracostomy**: Creation of an opening in the chest wall for drainage.
- **thoracotomy**: Surgical procedure for opening the chest wall in order to access the lungs, esophagus, trachea, aorta, heart, and diaphragm.

**Surgical to Anesthesia Code Crosswalk**
0258T, 0259T, 19272, 21750, 32035, 32036, 32095, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32151, 32200, 32201, 32215, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32503, 32504, 32505, 32520, 32522, 32540, 32650, 32653, 32654, 32655, 32656, 32657, 32662, 32663, 32664, 32665, 32666, 32669, 32670, 32671, 32672, 32673, 32800, 32810, 32940, 33238, 33245, 33246, 38381, 38530, 38794, 39000, 39010, 39200, 39220, 39501, 39503, 39520, 39530, 39531, 39540, 39541, 39545, 39560, 39561, 43328, 43334, 43335, 43336, 43337, 50526, 60270, 60505, 60521, 60522, 64752, 52060, 52061

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); decortication

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **decortication**: Removal of the cortical substance, the encapsulating or encasing material, of an organ, such as the kidneys or lungs.
- **empyema**: Accumulation of pus within the respiratory, or pleural, cavity.
- **fibrosis**: Formation of fibrous tissue as part of the restorative process.
- **fistula**: Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
- **iatrogenic**: Adversely induced in the patient; caused by medical treatment.
- **thoracotomy**: Surgical procedure for opening the chest wall in order to access the lungs, esophagus, trachea, aorta, heart, and diaphragm.

Surgical to Anesthesia Code Crosswalk
32220, 32225, 32310, 32320, 32651, 32652

ICD-9-CM Diagnostic Codes
- **163.0**: Malignant neoplasm of parietal pleura
- **163.8**: Malignant neoplasm of other specified sites of pleura
- **163.9**: Malignant neoplasm of pleura, unspecified site
- **197.2**: Secondary malignant neoplasm of pleura
- **239.1**: Neoplasm of unspecified nature of respiratory system
- **492.0**: Emphysematous bleb
- **510.0**: Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)
- **511.0**: Pleurisy without mention of effusion or current tuberculosis — (Use additional code to identify infectious organism)
- **512.0**: Spontaneous tension pneumothorax
- **512.1**: Iatrogenic pneumothorax
- **513.0**: Abscess of lung — (Use additional code to identify infectious organism)
- **515**: Postinflammatory pulmonary fibrosis — (Use additional code to identify infectious organism)
- **516.30**: Idiopathic interstitial pneumonia, not otherwise specified
- **516.31**: Idiopathic pulmonary fibrosis
- **516.32**: Idiopathic non-specific interstitial pneumonitis
- **516.33**: Acute interstitial pneumonitis
- **516.34**: Respiratory bronchiolitis interstitial lung disease
- **516.35**: Idiopathic lymphoid interstitial pneumonia
- **516.36**: Cryptogenic organizing pneumonia
- **516.37**: Desquamative interstitial pneumonia
- **518.89**: Other diseases of lung, not elsewhere classified — (Use additional code to identify infectious organism)

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); pulmonary resection with thoracoplasty

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
contusion. Superficial injury (bruising) produced by impact without a break in the skin.
laceration. Tearing injury; a torn, ragged-edged wound.
resection. Surgical removal of a part or all of an organ or body part.
thoraco-. Relating to the chest.
thoracotomy. Surgical procedure for opening the chest wall in order to access the lungs, esophagus, trachea, aorta, heart, and diaphragm.

Surgical to Anesthesia Code Crosswalk
32503, 32504, 32520, 32522, 32525

ICD-9-CM Diagnostic Codes
162.2 Malignant neoplasm of main bronchus
162.3 Malignant neoplasm of upper lobe, bronchus, or lung
162.4 Malignant neoplasm of middle lobe, bronchus, or lung
162.5 Malignant neoplasm of lower lobe, bronchus, or lung
162.8 Malignant neoplasm of other parts of bronchus or lung
162.9 Malignant neoplasm of bronchus and lung, unspecified site
170.3 Malignant neoplasm of ribs, sternum, and clavicle
171.4 Malignant neoplasm of connective and other soft tissue of thorax
197.0 Secondary malignant neoplasm of lung
198.5 Secondary malignant neoplasm of bone and bone marrow
198.89 Secondary malignant neoplasm of other specified sites
235.7 Neoplasm of uncertain behavior of trachea, bronchus, and lung
239.1 Neoplasm of unspecified nature of respiratory system
786.6 Swelling, mass, or lump in chest
861.20 Unspecified lung injury without mention of open wound into thorax
861.22 Lung laceration without mention of open wound into thorax
861.30 Unspecified lung injury with open wound into thorax
861.31 Lung contusion with open wound into thorax
861.32 Lung laceration with open wound into thorax
862.39 Injury to other specified intrathoracic organs with open wound into cavity
862.8 Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity
862.9 Injury to multiple and unspecified intrathoracic organs with open wound into cavity
V15.82 Personal history of tobacco use, presenting hazards to health

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4, 250.3.3.1; 100-4, 12, 140.1; 100-4, 12, 140.3; 100-4, 12, 140.3.3; 100-4, 12, 140.4; 100-4, 12, 140.4; 100-4, 12, 140.4.2

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); intrathoracic procedures on the trachea and bronchi

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
31760, 31766, 31770, 31775, 31781, 31786, 32442, 32815, 43312, 43314

ICD-9-CM Diagnostic Codes
161.0 Malignant neoplasm of glottis
161.1 Malignant neoplasm of supraglottis
161.2 Malignant neoplasm of subglottis
161.3 Malignant neoplasm of laryngeal cartilages
162.0 Malignant neoplasm of trachea
162.2 Malignant neoplasm of main bronchus
162.3 Malignant neoplasm of upper lobe, bronchus, or lung
162.4 Malignant neoplasm of middle lobe, bronchus, or lung
162.5 Malignant neoplasm of lower lobe, bronchus, or lung
171.4 Malignant neoplasm of connective and other soft tissue of thorax
176.4 Kaposi's sarcoma of lung
197.0 Secondary malignant neoplasm of lung
197.1 Secondary malignant neoplasm of mediastinum
197.3 Secondary malignant neoplasm of other respiratory organs
212.2 Benign neoplasm of trachea
212.3 Benign neoplasm of bronchus and lung
231.1 Carcinoma in situ of trachea
231.2 Carcinoma in situ of bronchus and lung
235.7 Neoplasm of uncertain behavior of trachea, bronchus, and lung
510.0 Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)
514 Pulmonary congestion and hypostasis — (Use additional code to identify infectious organism)
515 Postinflammatory pulmonary fibrosis — (Use additional code to identify infectious organism)
519.01 Infection of tracheostomy — (Use additional code to identify type of infection: 038.0-038.9, 682.1. Use additional code to identify organism: 041.00-041.9)
519.02 Mechanical complication of tracheostomy

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,10.4; 100-4,10.5; 100-4,4,10.4; 100-4,4,10.5; 100-4,4,320.3.2; 100-4,4,250.3.1.1; 100-4,4,12,140.3; 100-4,4,12,140.3.3; 100-4,4,12,140.3.4; 100-4,4,12,140.4.1; 100-4,4,12,140.4.2; 100-4,4,12,140.4.3; 100-4,4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for sternal debridement

Coding Tips
To report anesthesia provided during procedures of the skin, see code 00400. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
debridement. Removal of dead or contaminated tissue and foreign matter from a wound.

Surgical to Anesthesia Code Crosswalk
21627, 21750

ICD-9-CM Diagnostic Codes
170.3 Malignant neoplasm of ribs, sternum, and clavicle
198.5 Secondary malignant neoplasm of bone and bone marrow
213.3 Benign neoplasm of ribs, sternum, and clavicle
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
519.2 Mediastinitis — (Use additional code to identify infectious organism)
730.18 Chronic osteomyelitis, other specified sites — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
730.28 Unspecified osteomyelitis, other specified sites — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
730.88 Other infections involving bone diseases classified elsewhere, other specified sites — (Use additional code to identify organism: 041.1. Code first underlying disease: 002.0, 015.0-015.9)
733.49 Aseptic necrosis of other bone site — (Use additional code to identify major osseous defect, if applicable: 731.3)
875.1 Open wound of chest (wall), complicated
998.51 Infected postoperative seroma — (Use additional code to identify organism)
998.59 Other postoperative infection — (Use additional code to identify infection)
998.83 Non-healing surgical wound

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Surgical to Anesthesia Code Crosswalk

Correct code assignment is dependent upon the patient’s age, if a pump oxygenator was used, or if oxygenator pump with hypothermic circulatory arrest was performed. Code 00560 is reported when an oxygenator pump is not used on patients of any age. When pump is used, report code 00561 if the patient is younger than 1 year or 00562 when patient is older than 1 year. When hypothermic circulatory arrest is performed, report code 00566. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

pericardium. Thin and slippery case in which the heart lies that is lined with fluid so that the heart is free to pulse and move as it beats.

Surgical to Anesthesia Code Crosswalk

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Coding Tips</th>
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Coding Tips
These codes indicate the provision of anesthesia during coronary artery bypass grafting (surgical codes 33503, 33510-33514, 33516, and 33534-33536). Appropriate code selection is determined by whether or not a pump oxygenator is used. During direct coronary bypass without pump oxygenator, the heart is still beating and providing sole circulatory support for the patient. Laser myocardial revascularization and coronary bypass grafting are commonly performed without pump oxygenator. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bypass graft. Surgically created alternative blood vessel used to reroute blood flow around an area of obstruction or disease.

Surgical to Anesthesia Code Crosswalk
33500, 33503, 33504, 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536, S2205, S2206, S2207, S2208, S2209

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-3,160.9; 100-4,10.4; 100-4,4,10.5; 100-4,4,250.3.2
00580

Anesthesia for heart transplant or heart/lung transplant

Coding Tips
For physiological support during the harvesting of organs from a brain dead patient, see code 01990. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers. Benefits are provided under Medicare for cardiac transplantation when performed in a Medicare-approved facility that meets Medicare institutional coverage criteria.

Terms To Know
- **donor**: Person from whom tissues or organs are removed for transplantation.
- **harvest**: Removal of cells or tissue from their native site to be used as a graft or transplant to another part of the donor's body or placed into another person.
- **pneumonectomy**: Surgical removal of a lung or lung tissue.
- **transplant**: Insertion of an organ or tissue from one person or site into another.

Surgical to Anesthesia Code Crosswalk
0051T, 0052T, 0053T, 32851, 32852, 32853, 32854, 33935, 33945

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-3,260.9; 100-4,10.5; 100-4,4,250.3.3.1; 100-4,12,140.1;
100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4;
100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3;
100-4,12,140.4.4

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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Coding Tips
Do not report code 00600 for anesthesia provided at the time of a myelography or discography, see code 01935. For percutaneous image-guided spine and spinal cord anesthesia procedures, see codes 01935-01936. Code 00604 reflects anesthesia services performed at the time of any procedure on the cervical spine and spinal cord when performed on a patient in a sitting position.

Terms To Know

cervical. Relation to the cervical spine or to the cervix.
contrast material. Radiopaque substance placed into the body to enable a system or body structure to be visualized, such as nonionic and low osmolar contrast media (LOCM), ionic and high osmolar contrast media (HOCM), barium, and gadolinium.
discography. Radiographic imaging of an intervertebral disk, done after the injection of a contrast agent. Discography is reported with CPT codes 62290-62291 for the injection procedure, with the radiological supervision and interpretation reported separately using 72285 or 72295.
intervertebral disc. Fibrocartilaginous cushion found between the vertebral bodies of the spine and composed of the annulus fibrosus, or the outer fibrous ring, surrounding a soft, central elastic area called the nucleus pulposus.
myelography. Introduction of radiographic contrast medium into the sac surrounding the spinal cord and nerves.
spinal cord segment. Cervical, thoracic, lumbar, sacral, and coccygeal regions of the spinal cord with their root attachments of the spinal nerves.
supervision and interpretation. Radiology services that usually contain an invasive component and are reported by the radiologist for supervision of the procedure and the personnel involved with performing the examination, reading the film, and preparing the written report.

Surgical to Anesthesia Code Crosswalk
0090T, 0093T, 0096T, 0219T, 20251, 20680, 22010, 22100, 22110, 22210, 22220, 22318, 22319, 22326, 22551, 22554, 22590, 22595, 22600, 62268, 63001, 63015, 63020, 63040, 63045, 63050, 63051, 63075, 63081, 63170, 63180, 63182, 63191, 63194, 63196, 63198, 63265, 63270, 63275, 63280, 63285, 63300, 63304, 63600, 63610, 63615, 63655, 64772, 64802, 64804

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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00620-00622

00620  Anesthesia for procedures on thoracic spine and cord; not otherwise specified

00622  thoracolumbar sympathectomy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
sympathectomy. Surgical interruption or transection of a sympathetic nervous system pathway.
sympathetic nerves. Self-regulating nerves that are part of the autonomic nervous system and that innervate the involuntary motor systems that prepare the body for intense activity.
thoracolumbar. Thoracic and lumbar regions of the back and spine.

Surgical to Anesthesia Code Crosswalk


ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00625-00626

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

Coding Tips
Correct code assignment is determined upon the use of one lung ventilation. Report code 00625 when one lung ventilation is not provided; 00626 when it is. If anesthesia is performed for thoracic procedures other than those of the spine, see codes 00540-00541.

Terms To Know
anterior. Situated in the front area or toward the belly surface of the body.
kyphosis. Abnormal posterior convex curvature of the spine, usually in the thoracic region, resembling a hunchback.
myelo-. Relating to bone marrow or the spinal cord.
myelopathy. Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.
spondylolisthesis. Forward displacement of one vertebra slipping over another, usually in the fourth or fifth lumbar area.
thoraco-. Relating to the chest.

Surgical to Anesthesia Code Crosswalk
22112, 22222, 22556, 22808, 22810, 22830, 22855, 63064, 63077, 63085, 63087, 63301, 63302, 63305, 63306

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Also not with 00626: 00625

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00630-00634

00630  Anesthesia for procedures in lumbar region; not otherwise specified
00632  lumbar sympathectomy
00634  chemonucleolysis

Coding Tips
The appropriate modifiers indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
sympathectomy. Surgical interruption or transection of a sympathetic nervous system pathway.

Surgical to Anesthesia Code Crosswalk

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4
00635

00635  Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture

Coding Tips

Code 00635 may be reported to describe anesthesia management for the removal of cerebral spinal fluid for conditions resulting in increased fluid production or pressure, or for therapeutic nerve blocks. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

ataxia. Defect in muscular coordination, seen especially when voluntary muscular movements are attempted.

chemonucleolysis. Process of injecting a chemolytic agent to dissolve the nucleus pulposus of a herniated intervertebral disk. Synonym(s): discolysis.
diagnostic. Examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.
encephalitis. Inflammation of the brain, often caused by viral or bacterial infection.
encephalopathy. Condition affecting brain structure.
meninges. Tough membranous protectors of the central nervous system that cover the brain and spinal cord comprising three layers: the dura mater, arachnoid mater, and pia mater.
eningitis. Inflammation of meningeal layers of the brain.
myelodysplastic syndrome. Neoplasm of lymphatic and hematopoietic tissues, affecting the spinal cord. Report this disorder with ICD-9-CM code 238.72-238.75.
polynuertis. Inflammation of several peripheral nerves occurring at the same time.
sympathectomy. Surgical interruption or transection of a sympathetic nervous system pathway.
syringomyelia. Progressive condition that may be from developmental origin or caused by trauma, tumor, hemorrhage, or infarction. An abnormal cavity (syrinx) forms in the spinal cord and enlarges over time, resulting in symptoms of muscle weakness; stiffness in the back, shoulders, arms, or legs; atrophy; headaches; dissociated memory loss; loss of sensory ability to feel pain; and extremes of hot or cold temperatures.

Surgical to Anesthesia Code Crosswalk

22102, 62268, 62269, 62270, 62272, 96450

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00640

Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

closed fracture. Break in a bone without a concomitant opening in the skin.
degeneration. Deterioration of an anatomic structure due to disease or other factors.
dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.
idiopathic. Having no known cause.
manipulation. Skillful treatment by hand to reduce fractures and dislocations, or provide therapy through forcible passive movement of a joint beyond its active limit of motion.
neuritis. Inflammation of a nerve or group of nerves, often manifested by loss of function and reflexes, pain, and numbness or tingling.
osteoarthritis. Bone degeneration caused by the breakdown of the bony matrix without equivalent regeneration, resulting in a weak, porous, fragile bone structure.
radiculitis. Pain along an inflamed nerve, with inflammation of the root of the associated spinal nerve.
stenosis. Narrowing or constriction of a passage.

Surgical to Anesthesia Code Crosswalk
20220, 20225, 20615, 20982, 22102, 22305, 22310, 22315, 22505, 22526, 29220, 62269, 62272, 64561, S2348

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **instrumentation.** Use of a tool for therapeutic reasons.
- **kyphosis.** Abnormal posterior convex curvature of the spine, usually in the thoracic region, resembling a hunchback.
- **lordosis.** Congenital condition in which there is an exaggerated inward curvature of the lower back.
- **myelopathy.** Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.
- **neuritis.** Inflammation of a nerve or group of nerves, often manifested by loss of function and reflexes, pain, and numbness or tingling.
- **osteoporosis.** Bone degeneration caused by the breakdown of the bony matrix without equivalent regeneration, resulting in a weak, porous, fragile bone structure.
- **scoliosis.** Congenital condition of lateral curvature of the spine, often associated with other spinal column defects, congenital heart disease, or genitourinary abnormalities. It may also be associated with spinal muscular atrophy, cerebral palsy, or muscular dystrophy.
- **spina bifida.** Lack of closure in the vertebral column with protrusion of the spinal cord through the defect, often in the lumbosacral area. This condition can be recognized by the presence of alpha-fetoproteins in the amniotic fluid and may present alone or in conjunction with other anomalies, and with or without hydrocephalus. Spina bifida is reported with a code from ICD-9-CM category 741, with a mandatory fifth digit specifying the location of the lesion.
- **syringomyelia.** Progressive condition that may be from developmental origin or caused by trauma, tumor, hemorrhage, or infarction. An abnormal cavity (syrinx) forms in the spinal cord and enlarges over time, resulting in symptoms of muscle weakness; stiffness in the back, shoulders, arms, or legs; atrophy; headaches; dissociated memory loss; loss of sensory ability to feel pain; and extremes of hot or cold temperatures.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

OM References
100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

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| Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

00700-00702

00700  Anesthesia for procedures on upper anterior abdominal wall; not otherwise specified
00702  percutaneous liver biopsy

Coding Tips
To report anesthesia during procedures on the upper posterior abdominal wall, see code 00730. For anesthesia during hernia repairs, see codes 00750-00756. Anesthesia provided during gastrointestinal endoscopies is reported with code 00740. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
cirrhosis. Disease of the liver that has the characteristics of intertwining band of fibrous tissue that divides the parenchyma into micro- and macronodular areas, which cause the liver to stop functioning over time.
congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
esophagitis. Inflammation of the esophagus.
lipoma. Benign tumor containing fat cells and the most common of soft tissue lesions, which are usually painless and asymptomatic, with the exception of an angiolipoma.
myopathy. Any disease process within muscle tissue.
percutaneous. Through the skin.
peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.

Surgical to Anesthesia Code Crosswalk
0141T, 11005, 11011, 15758, 15770, 20102, 20500, 20501, 20520, 20525, 20555, 22900, 22901, 22902, 22903, 22904, 22905, 43750, 43760, 47000, 47490, 47500, 47505, 47510, 47511, 47525, 47530, 47552, 47630, 48102, 48110, 49041, 49082, 49083, 49084, 49111, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 62230, G0341, S2102

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for procedures on upper posterior abdominal wall

Coding Tips
To report anesthesia during procedures on the upper anterior abdominal wall, see code 00700. For anesthesia during hernia repairs, see codes 00750-00756. Anesthesia provided during gastrointestinal endoscopies is reported with code 00740. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
11011, 15758, 15770, 20102, 20200, 20205, 20500, 20501, 20520, 20525, 20555, 21920, 21925, 21930, 21931, 21932, 21933, 21935, 21936, 22904, 22905, 49411

ICD-9-CM Diagnostic Codes
171.5 Malignant neoplasm of connective and other soft tissue of abdomen
195.8 Malignant neoplasm of other specified sites
198.89 Secondary malignant neoplasm of other specified sites
214.1 Lipoma of other skin and subcutaneous tissue
215.5 Other benign neoplasm of connective and other soft tissue of abdomen
215.8 Other benign neoplasm of connective and other soft tissue of other specified sites
228.01 Hemangiomia of skin and subcutaneous tissue
229.8 Benign neoplasm of other specified sites
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
359.0 Congenital hereditary muscular dystrophy
359.1 Hereditary progressive muscular dystrophy
359.6 Symptomatic inflammatory myopathy in diseases classified elsewhere — (Code first underlying disease: 135, 140.0-208.9, 277.30-277.39, 446.0, 710.0, 710.1, 710.2, 714.0)
359.81 Critical illness myopathy
359.89 Other myopathies
443.81 Peripheral angiopathy in diseases classified elsewhere — (Code first underlying disease: 249.7, 250.7)
701.5 Other abnormal granulation tissue
728.0 Infective myositis
728.81 Interstitial myositis
728.86 Necrotizing fasciitis — (Use additional code to identify infectious organism, 041.00-041.89, 785.4, if applicable)
728.87 Muscle weakness (generalized)

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00740

00740  Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum

Coding Tips

It is expected that the physician performing the endoscopy will provide sedation. Therefore, unless another condition supports the medical necessity of the anesthesiologist's presence, this service will be denied. For those patients requiring the presence of an anesthesiologist because of massive upper gastrointestinal bleeding, use the appropriate ICD-9-CM code for gastrointestinal hemorrhage.

Terms To Know

angiodysplasia. Vascular abnormalities, with or without bleeding.

cirrhosis. Disease of the liver that has the characteristics of intertwining bands of fibrous tissue that divides the parenchyma into micro- and macronodular areas, which cause the liver to stop functioning over time.

duodenum. First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.

endoscopy. Visual inspection of the body using a fiberoptic scope.

hemorrhage. Internal or external bleeding with loss of significant amounts of blood.

in situ. Located in the natural position or contained within the origin site, not spread into neighboring tissue.

jejenum. Highly vascular upper two-fifths of the small intestine, extending from the duodenum to the ileum.

pylorus. Lower portion of the stomach, which opens into the duodenum.

varices. Enlarged, dilated, or twisted, turning veins.

Surgical to Anesthesia Code Crosswalk

0008T, 0057T, 0133T, 43191, 43192, 43193, 43194, 43195, 43196, 43197, 43198, 43200, 43201, 43202, 43204, 43205, 43206, 43211, 43212, 43213, 43214, 43215, 43216, 43217, 43219, 43220, 43226, 43227, 43228, 43229, 43231, 43232, 43233, 43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43252, 43253, 43254, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43266, 43267, 43268, 43269, 43270, 43271, 43272, 43274, 43275, 43276, 43277, 43278, 43600, 44100, 44500, 47553, 47554, 47555, 47556, 91060

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,10.4; 100-4,10.5; 100-4,250.3.2; 100-4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for hernia repairs in upper abdomen; not otherwise specified

lumbar and ventral (incisional) hernias and/or wound dehiscence

omphalocele

transabdominal repair of diaphragmatic hernia

Coding Tips
Appropriate code selection is dependent upon the type of hernia repaired. For repair of hernia of the lower abdomen, see codes 00830-00836. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

Surgical to Anesthesia Code Crosswalk
39540, 39541, 49540, 49541, 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49600, 49605, 49606, 49610, 49611, 49652, 49653, 49654, 49655, 49656, 49657, 49900, S2075, S2076

ICD-9-CM Diagnostic Codes
551.1 Umbilical hernia with gangrene
551.20 Unspecified ventral hernia with gangrene
551.29 Other ventral hernia with gangrene
551.3 Diaphragmatic hernia with gangrene
551.8 Hernia of other specified sites, with gangrene
552.1 Umbilical hernia with obstruction
552.20 Unspecified ventral hernia with obstruction
552.21 Incisional hernia with obstruction
552.29 Other ventral hernia with obstruction
552.3 Diaphragmatic hernia with obstruction
553.1 Umbilical hernia without mention of obstruction or gangrene
553.20 Unspecified ventral hernia without mention of obstruction or gangrene
553.21 Incisional hernia without mention of obstruction or gangrene
553.29 Other ventral hernia without mention of obstruction or gangrene

Diaphragmatic hernia without mention of obstruction or gangrene
Disruption of cesarean wound, unspecified as to episode of care
Disruption of cesarean wound, with delivery, with mention of postpartum complication
Disruption of cesarean wound, postpartum condition or complication
Other complication of obstetrical surgical wounds, with delivery, with mention of postpartum complication
Other complications of obstetrical surgical wounds, postpartum condition or complication
Other congenital anomalies of abdominal wall
Diaphragm injury without mention of open wound into cavity
Disruption of internal operation (surgical) wound
Disruption of external operation (surgical) wound
Non-healing surgical wound

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for all procedures on major abdominal blood vessels

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.
atherosclerosis. Buildup of yellowish plaques composed of cholesterol and lipoid material within the arteries.

blood vessel. Tubular channel consisting of arteries, veins, and capillaries that transports blood throughout the body.
duodenum. First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.

embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.
ileum. Lower portion of the small intestine, from the jejunum to the cecum.
jejunum. Highly vascular upper two-fifths of the small intestine, extending from the duodenum to the ileum.
peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.

thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

Surgical to Anesthesia Code Crosswalk
0078T, 0143T, 0234T, 0235T, 0236T, 0238T, 0338T, 0339T, 34151, 34502, 34820, 34830, 34831, 34832, 34833, 35081, 35082, 35083, 35091, 35092, 35111, 35112, 35121, 35122, 35221, 35281, 35331, 35341, 35351, 35361, 35363, 35450, 35480, 35481, 35482, 35490, 35531, 35535, 35536, 35537, 35538, 35539, 35540, 35560, 35582, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35840, 35870, 35907, 36160, 36200, 36221, 36245, 36246, 36247, 36251, 36252, 36253, 36254, 36260, 36261, 36262, 37140, 37145, 37160, 37180, 37181, 37617

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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splenomegaly.

Tube. Laparoscopy can be performed for diagnostic purposes alone or included laparoscopy.

Inflammation of the esophagus.

Obstruction of a blood vessel resulting from a clot or foreign embolism.

First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.

Failure of the smooth muscles within the gastrointestinal tract to relax at points of junction; most commonly referring to the esophagogastric sphincter's failure to relax when swallowing.

Abnormal accumulation of free fluid in the abdominal cavity, causing distention and tightness in addition to shortness of breath as the fluid accumulates. Ascites is usually an underlying disorder and can be a manifestation of any number of diseases.

First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.

Obstruction of a blood vessel resulting from a clot or foreign substance.

Inflammation of the esophagus.

Within the cavity or space created by the double-layered sac that lines the abdominopelvic walls and forms a covering for the internal organs.

Direct visualization of the peritoneal cavity, outer fallopian tubes, uterus, and ovaries utilizing a laparoscope, a thin, flexible fiberoptic tube. Laparoscopy can be performed for diagnostic purposes alone or included as part of other surgical procedures accomplished by this approach.

Inflammation of the lymph glands.

Lower portion of the stomach, which opens into the duodenum.

Enlarged spleen.

Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

0142T, 0143T, 0155T, 0156T, 0157T, 0158T, 0312T, 0313T, 0336T, 03800, 03810, 03811, 03812, 03832, 03952, 03954, 03958, 04127, 04130, 04133, 04136, 04140, 04141, 04143, 04144, 04145, 04146, 04147, 04150, 04151, 04152, 04153, 04155, 04156, 04160, 04180, 04186, 04187, 04188, 04202, 04206, 04207, 04208, 04210, 04211, 04227, 04312, 04602, 04800, 04820, 04850, 07010, 07011, 07015, 07017, 07300, 07370, 07371, 07380, 07381, 07382, 07400, 07420, 07425, 07460, 07470, 07490, 07500, 07560, 07561, 07562, 07563, 07564, 07570, 07600, 07605, 07610, 07612, 47620, 47700, 47711, 47712, 47715, 47716, 47719, 47720, 47721, 47740, 47741, 47760, 47765, 47778, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48005, 48020, 48100, 48105, 48120, 48148, 48180, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49040, 49041, 49203, 49204, 49205, 49220, 49324, 49325, 49402, 49405, 49406, 49411, 49418, 49425, 49426, 49427, 49428, 49429, 49452, 49563, 49904, 51906, 64755, 64760, G0341, G0342, G0343, S2053, S2054, S2079, S2102, S2213

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Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
hemorrhage. Internal or external bleeding with loss of significant amounts of blood.

Surgical to Anesthesia Code Crosswalk
0314T, 0336T, 47120, 47122, 47125, 47130, 47134, 47140, 47141, 47142, 47350, 47360, 47361, 47362

ICD-9-CM Diagnostic Codes
155.0 Malignant neoplasm of liver, primary
155.2 Malignant neoplasm of liver, not specified as primary or secondary
197.7 Secondary malignant neoplasm of liver
211.5 Benign neoplasm of liver and biliary passages
230.8 Carcinoma in situ of liver and biliary system
235.3 Neoplasm of uncertain behavior of liver and biliary passages
277.31 Familial Mediterranean fever — (Use additional code to identify any associated intellectual disabilities)
277.4 Disorders of bilirubin excretion — (Use additional code to identify any associated intellectual disabilities)
571.5 Cirrhosis of liver without mention of alcohol — (Code first, if applicable, viral hepatitis (acute) (chronic): 070.0-070.9)
571.6 Biliary cirrhosis
571.8 Other chronic nonalcoholic liver disease
572.0 Abscess of liver
573.8 Other specified disorders of liver
576.8 Other specified disorders of biliary tract
751.60 Unspecified congenital anomaly of gallbladder, bile ducts, and liver
751.62 Congenital cystic disease of liver
751.69 Other congenital anomaly of gallbladder, bile ducts, and liver
782.4 Jaundice, unspecified, not of newborn
789.1 Hepatomegaly
864.02 Liver laceration, minor, without mention of open wound into cavity
864.03 Liver laceration, moderate, without mention of open wound into cavity
864.04 Liver laceration, major, without mention of open wound into cavity
864.05 Liver injury without mention of open wound into cavity, unspecified laceration
864.09 Other liver injury without mention of open wound into cavity
864.12 Liver laceration, minor, with open wound into cavity
864.13 Liver laceration, moderate, with open wound into cavity
864.14 Liver laceration, major, with open wound into cavity
864.19 Other liver injury with open wound into cavity
998.11 Hemorrhage complicating a procedure
998.2 Accidental puncture or laceration during procedure
998.31 Disruption of internal operation (surgical) wound
V59.6 Liver donor

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00794
00794  Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; pancreatectomy, partial or total (eg, Whipple procedure)

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
48140, 48145, 48146, 48150, 48152, 48153, 48154, 48155, 48160

ICD-9-CM Diagnostic Codes
157.0  Malignant neoplasm of head of pancreas
157.1  Malignant neoplasm of body of pancreas
157.2  Malignant neoplasm of tail of pancreas
157.3  Malignant neoplasm of pancreatic duct
157.4  Malignant neoplasm of islets of Langerhans — (Use additional code to identify any functional activity)
157.6  Malignant neoplasm of other specified sites of pancreas
157.7  Secondary malignant neoplasm of other digestive organs and spleen
157.8  Malignant neoplasm of pancreas, part unspecified
157.9  Pancreas replaced by transplant — (Use additional code to identify any functional activity)
211.7  Benign neoplasm of islets of Langerhans — (Use additional code to identify any functional activity)
249.40 Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified — (Use additional code to identify any associated insulin use: V58.67)
249.41 Secondary diabetes mellitus with renal manifestations, uncontrolled — (Use additional code to identify any associated insulin use: V58.67)
250.01 Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled
250.02 Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled
250.41 Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 81.81, 83.81, 85.1-85.9)
250.43 Diabetes with renal manifestations, type I [juvenile type], uncontrolled — (Use additional code to identify manifestation: 81.81, 83.81, 85.1-85.9)

250.81 Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 707.10-707.19, 707.8, 707.9, 731.8)
250.83 Diabetes with other specified manifestations, type I [juvenile type], uncontrolled — (Use additional code to identify manifestation: 707.10-707.19, 707.8, 707.9, 731.8)
577.0  Acute pancreatitis
577.1  Chronic pancreatitis
577.2  Cyst and pseudocyst of pancreas
577.8  Other specified disease of pancreas
863.81 Pancreas head injury without mention of open wound into cavity
863.82 Pancreas body injury without mention of open wound into cavity
863.84 Pancreas injury, multiple and unspecified sites, without mention of open wound into cavity
863.94 Pancreas injury, multiple and unspecified sites, with open wound into cavity
V42.83 Pancreas replaced by transplant

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4.10.4; 100-4,4.10.5; 100-4,4.250.3.2; 100-4,4.250.3.3.1; 100-4,4.12.1; 100-4,12.140.3.1; 100-4,12.140.3.3; 100-4,12.140.4.1; 100-4,12.140.4.2; 100-4,12.140.4.3; 100-4,12.140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)

Coding Tips
Do not report code 00796 when anesthesia is used for liver harvesting. For anesthesia performed for the harvesting of a liver from a brain dead patient, see code 01990. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- atresia: Congenital closure or absence of a tubular organ or an opening to the body surface.
- cirrhosis: Disease of the liver that has the characteristics of intertwining bands of fibrous tissue that divides the parenchyma into micro- and macro nodular areas, which cause the liver to stop functioning over time.
- congenital biliary atresia: Fatal infection affecting the biliary tree in which there is progressive sclerosing and destruction of the intrahepatic ducts.
- necrosis: Death of cells or tissue within a living organ or structure.
- transplant: Insertion of an organ or tissue from one person or site into another.

Surgical to Anesthesia Code Crosswalk
47135, 47136

ICD-9-CM Diagnostic Codes
- 155.0 Malignant neoplasm of liver, primary
- 197.7 Secondary malignant neoplasm of liver
- 273.4 Alpha-1-antitrypsin deficiency — (Use additional code to identify any associated intellectual disabilities)
- 570 Acute and subacute necrosis of liver
- 571.49 Other chronic hepatitis
- 571.5 Cirrhosis of liver without mention of alcohol — (Code first, if applicable, viral hepatitis (acute) (chronic): 070.0-070.9)
- 571.6 Biliary cirrhosis
- 571.8 Other chronic nonalcoholic liver disease
- 571.9 Unspecified chronic liver disease without mention of alcohol
- 572.8 Other sequelae of chronic liver disease
- 573.8 Other specified disorders of liver
- 576.2 Obstruction of bile duct
- 576.8 Other specified disorders of biliary tract
- 751.61 Congenital biliary atresia
- 751.62 Congenital cystic disease of liver
- 751.69 Other congenital anomaly of gallbladder, bile ducts, and liver

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
- 100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
endocrine. Secretions distributed within the bloodstream that control metabolism.
hypothyroidism. Underproduction of thyroid hormone.
morbid obesity. Accumulation of excess fat in the subcutaneous connective tissue with increased weight beyond the limits of skeletal requirements, defined as 125 percent or more over the ideal body weight. It is often associated with serious conditions that can become life threatening, such as diabetes, hypertension, and arteriosclerosis.

Surgical to Anesthesia Code Crosswalk
43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2082

ICD-9-CM Diagnostic Codes
244.9 Unspecified hypothyroidism
253.8 Other disorders of the pituitary and other syndromes of diencephalohypophyseal origin
255.8 Other specified disorders of adrenal glands
259.9 Unspecified endocrine disorder
278.00 Obesity, unspecified — (Use additional code to identify Body Mass Index (BMI), if known: V85.0-V85.54) (Use additional code to identify any associated intellectual disabilities)
278.01 Morbid obesity — (Use additional code to identify Body Mass Index (BMI), if known: V85.0-V85.54)
564.2 Postgastric surgery syndromes
998.59 Other postoperative infection — (Use additional code to identify infection)
998.89 Other specified complications
V45.3 Intestinal bypass or anastomosis status
V53.51 Fitting and adjustment of gastric lap band

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00800-00802
00800  Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified
00802  panniculectomy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
angiodysplasia. Vascular abnormalities, with or without bleeding.
fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
hemangioma. Benign neoplasm arising from vascular tissue or malformations of vascular structures. It is most commonly seen in children and infants as a tumor of newly formed blood vessels due to malformed fetal angioblastic tissues.
in situ. Located in the natural position or contained within the origin site, not spread into neighboring tissue.
myopathy. Any disease process within muscle tissue.
peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.
peritonitis. Inflammation and infection within the peritoneal cavity, the space between the membrane lining the abdominopelvic walls and covering the internal organs.
polymyositis. Systemic necrotizing vasculitis of small and medium arteries that results in the infarction and scarring within the affected organs.

Surgical to Anesthesia Code Crosswalk
11005, 15758, 15770, 15830, 15831, 20102, 20300, 20501, 20520, 20525, 20555, 22900, 22901, 22902, 22903, 22904, 22905, 44312, 44430, 44901, 44903, 49021, 49080, 49081, 49082, 49083, 49084, 49180, 49400, 49411, 49422, 49423, 49424, 49442, 49450, 50690, 51000, 51005, 51100, 51101, 51102, 51705, 51710, 59070, 59072, 59074, 59076, 62230, 69645, 52400, 52401, 52402, 52403, 52404, 52405

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3,3; 100-4,4,250.3,3,1; 100-4,4,250.3,3,3; 100-4,12,140.1; 100-4,12,140.4; 100-4,12,140.4,1; 100-4,12,140.4,2; 100-4,12,140.4,3; 100-4,12,140.4,4

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Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

Coding Tips
It is expected that the physician performing the endoscopy will provide sedation. Therefore, unless another condition supports the medical necessity of the anesthesiologist's presence, this service will be denied. For those patients requiring the presence of an anesthesiologist because of massive lower gastrointestinal bleeding, use the appropriate code for gastrointestinal hemorrhage.

Terms To Know
- **Colitis.** Inflammation of the colon, caused by an infection or external influences such as laxatives, radiation, or antibiotics. Diagnosis codes are selected by cause or type.
- **Distal.** Located farther away from a specified reference point.
- **Duodenum.** First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.
- **Endoscopy.** Visual inspection of the body using a fiberoptic scope.
- **Fistula.** Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
- **Hemorrhage.** Internal or external bleeding with loss of significant amounts of blood.
- **Ileum.** Lower portion of the small intestine, from the jejunum to the cecum.
- **Ileus.** Persistent obstruction of the intestines coded in different chapters in ICD-9-CM based on its type or cause, location, and whether it occurs in a newborn.
- **In Situ.** Located in the natural position or contained within the origin site, not spread into neighboring tissue.
- **Jejunum.** Highly vascular upper two-fifths of the small intestine, extending from the duodenum to the ileum.
- **Polyp.** Small growth on a stalk-like attachment projecting from a mucous membrane.
- **Volvulus.** Twisting, knotting, or entanglement of the bowel on itself that may quickly compromise oxygen supply to the intestinal tissues. A volvulus usually occurs at the sigmoid and ileocecal areas of the intestines.

Surgical to Anesthesia Code Crosswalk

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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00820

00820  Anesthesia for procedures on lower posterior abdominal wall

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

endometriosis. Aberrant uterine mucosal tissue appearing in areas of the pelvic cavity outside of its normal location, lining the uterus, and inflaming surrounding tissues often resulting in infertility and spontaneous abortion.

fistula. Abnormal lube-like passage between two body cavities or organs or from an organ to the outside surface.

necrosis. Death of cells or tissue within a living organ or structure.

perforation. Hole in an object, organ, or tissue, or the act of punching or boring holes through a part.

peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.

peritonitis. Inflammation and infection within the peritoneal cavity, the space between the membrane lining the abdominopelvic walls and covering the internal organs.

polyarteritis nodosa. Systemic necrotizing vasculitis of small and medium arteries that results in the infarction and scarring within the affected organs.

Surgical to Anesthesia Code Crosswalk
15758, 15770, 20102, 20500, 20501, 20520, 20525, 20555, 21920, 21925, 21930, 21931, 21932, 21933, 21935, 21936, 22904, 22905, 49061, 49180, 49411, 49423, 49424, 50389, 50394, 50398, 50559, 50561, 50684, 50951, 50955, 50957, 50959, 50961

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4, 4.10.4; 100-4, 4.10.5; 100-4, 4.250.3.2; 100-4, 4.250.3.3.1; 100-4, 4.12, 140.1; 100-4, 4.12, 140.3; 100-4, 4.12, 140.3.3; 100-4, 4.12, 140.3.4; 100-4, 4.12, 140.4.1; 100-4, 4.12, 140.4.2; 100-4, 4.12, 140.4.3; 100-4, 4.12, 140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**00830-00836**

**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, infants younger than 37 weeks gestational age at birth and younger than 50 weeks gestational age at time of surgery

**Coding Tips**

Do not use code 00830 or 00832 when the patient is younger than 1 year of age. When the anesthesia is provided to an infant 1 year of age or younger, see codes 00834 and 00836. For anesthesia during upper abdominal hernia repairs (diaphragmatic, ventral, etc.), see codes 00750-00756. Do not report 99100 in addition to codes 00834-00836.

**Terms To Know**

**gangrene.** Death of tissue, usually resulting from a loss of vascular supply, followed by a bacterial attack or onset of disease.

**hernia.** Protrusion of a body structure through tissue.

**hydrocele.** Serous fluid that collects in the tunica vaginalis, the spermatic cord, or the canal of Nuck. Hydroceles may be congenital, due to a defect in the tunica vaginalis, or secondary, due to fluid accumulation, injury, infection, or radiotherapy.

**inguinal.** Within the groin region.

**obstruction.** Blockage that prevents normal function of the valve or structure.

**Surgical to Anesthesia Code Crosswalk**

49491, 49492, 49495, 49496, 49500, 49501, 49505, 49507, 49520, 49521, 49525, 49530, 49553, 49555, 49557, 49560, 49561, 49565, 49566, 49580, 49585, 49590, 49652, 49653, 49654, 49655, 49656, 49657, 55340, 52075

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.31; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified

Coding Tips
Anesthesia performed during amniocentesis is reported using code 00842; abdominoperineal resection is reported using code 00844. Anesthesia provided at the time of a radical hysterectomy is reported using code 00846; pelvic exenteration, code 00848; and tubal ligation/transection, code 00851. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
dysphagia. Difficulty and pain upon swallowing.
gangrene. Death of tissue, usually resulting from a loss of vascular supply, followed by a bacterial attack or onset of disease.
intraperitoneal. Within the cavity or space created by the double-layered sac that lines the abdominopelvic walls and forms a covering for the internal organs.
laparoscopy. Direct visualization of the peritoneal cavity, outer fallopian tubes, uterus, and ovaries utilizing a laparoscope, a thin, flexible fiberoptic tube.
lymphadenitis. Inflammation of the lymph nodes.
peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**00842**

Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis

**Coding Tips**

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**

59000, 59001, 59012, 59015, 59070

**ICD-9-CM Diagnostic Codes**

- **646.03** Papyraceous fetus, antepartum — (Use additional code to further specify complication)
- **646.13** Edema or excessive weight gain, antepartum — (Use additional code to further specify complication)
- **646.83** Other specified complication, antepartum — (Use additional code to further specify complication)
- **646.83** Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication — (Use additional code to identify the specific coagulation defect: 286.0-286.9, 287.0-287.9, 289.0-289.9)
- **655.83** Other known or suspected fetal abnormality, not elsewhere classified, affecting management of mother, antepartum condition or complication
- **655.83** Fetal-maternal hemorrhage, antepartum condition or complication
- **658.03** Oligohydramnios, antepartum
- **658.43** Infection of amniotic cavity, antepartum
- **658.83** Other problem associated with amniotic cavity and membranes, antepartum
- **659.53** Elderly primigravida, antepartum
- **659.63** Elderly multigravida, antepartum condition or complication
- **659.73** Abnormality in fetal heart rate or rhythm, antepartum condition or complication
- **759.83** Fragile X syndrome
- **762.7** Fetus or newborn affected by chorioamnionitis — (Use additional code(s) to further specify condition)
- **772.0** Fetal blood loss affecting newborn — (Use additional code(s) to further specify condition)
- **782.81** Encounter for fetal anatomic survey

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; abdominoperineal resection

Coding Tips
For anesthesia during procedures of the upper abdomen, see codes 00700-00797. This code is appropriate for anesthesia provided during abdominoperineal resections, see codes 00842 and 00846-00851 for other specific procedures performed on the lower abdomen. Code 00840 is used to report anesthesia during other types of lower abdominal procedures. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
colostomy. Artificial surgical opening anywhere along the length of the colon to the skin surface for the diversion of feces.
diverticulosis. Sacklike pouches of the mucous membrane lining the intestine, herniating through the muscular wall of the colon, and occurring without inflammation.
enterostomy. Surgically created opening into the intestine through the abdominal wall.
peritonitis. Inflammation and infection within the peritoneal cavity, the space between the membrane lining the abdominopelvic walls and covering the internal organs.
resection. Surgical removal of a part or all of an organ or body part.

Surgical to Anesthesia Code Crosswalk
41147, 44210, 44312, 46110, 46111, 46112, 46113, 46114, 46116, 46119, 45120, 45121, 45135, 45395, 45397, 45550

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3,2; 100-4,4,250.3,3,1; 100-4,4,250.3,3,3; 100-4,4,250.3,3,5; 100-4,4,250.3,4; 100-4,4,250.3,4,1; 100-4,4,250.3,4,2; 100-4,4,250.3,4,3; 100-4,4,250.3,4,4

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Anesthesia for intraperitoneal procedures in lower abdomen
including laparoscopy; radical hysterectomy

**Coding Tips**

See code 00848 for anesthesia provided during pelvic exenteration surgery.

**Surgical to Anesthesia Code Crosswalk**

57531, 58200, 58210, 58548, 58951, 58952, 58953, 58954, 58956

**ICD-9-CM Diagnostic Codes**

179 Malignant neoplasm of uterus, part unspecified
180.0 Malignant neoplasm of endocervix
180.1 Malignant neoplasm of exocervix
182.0 Malignant neoplasm of corpus uteri, except isthmus
182.1 Malignant neoplasm of isthmus
182.8 Malignant neoplasm of other specified sites of body of uterus
183.0 Malignant neoplasm of ovary — (Use additional code to identify any functional activity)
183.2 Malignant neoplasm of fallopian tube
183.3 Malignant neoplasm of broad ligament of uterus
183.4 Malignant neoplasm of parametrium of uterus
183.5 Malignant neoplasm of round ligament of uterus
183.8 Malignant neoplasm of other specified sites of uterine adnexa
183.9 Malignant neoplasm of uterine adnexas, unspecified site
184.0 Malignant neoplasm of vagina
196.2 Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
197.5 Secondary malignant neoplasm of large intestine and rectum
197.6 Secondary malignant neoplasm of retroperitoneum and peritoneum
198.1 Secondary malignant neoplasm of other urinary organs
198.6 Secondary malignant neoplasm of ovary
198.82 Secondary malignant neoplasm of genital organs
198.89 Secondary malignant neoplasm of other specified sites
199.0 Disseminated malignant neoplasm
219.0 Benign neoplasm of cervix uteri
233.1 Carcinoma in situ of cervix uteri
235.4 Neoplasm of uncertain behavior of retroperitoneum and peritoneum
236.0 Neoplasm of uncertain behavior of uterus

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; pelvic exenteration

Coding Tips
See code 00846 for anesthesia provided during a radical hysterectomy.
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
45126, 51597, 58240

ICD-9-CM Diagnostic Codes
153.0 Malignant neoplasm of hepatic flexure
153.1 Malignant neoplasm of transverse colon
153.2 Malignant neoplasm of descending colon
153.3 Malignant neoplasm of sigmoid colon
153.4 Malignant neoplasm of cecum
153.5 Malignant neoplasm of appendix
153.6 Malignant neoplasm of ascending colon
153.7 Malignant neoplasm of splenic flexure
154.0 Malignant neoplasm of rectosigmoid junction
154.1 Malignant neoplasm of rectum
154.2 Malignant neoplasm of anal canal
154.8 Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
180.0 Malignant neoplasm of endocervix
180.1 Malignant neoplasm of exocervix
182.0 Malignant neoplasm of corpus uteri, except isthmus
182.1 Malignant neoplasm of isthmus
182.8 Malignant neoplasm of other specified sites of body of uterus
183.0 Malignant neoplasm of ovary — (Use additional code to identify any functional activity)
183.2 Malignant neoplasm of fallopian tube
183.3 Malignant neoplasm of broad ligament of uterus
183.4 Malignant neoplasm of parametrium of vagina
183.5 Malignant neoplasm of round ligament of uterus
184.0 Malignant neoplasm of vagina
184.8 Malignant neoplasm of other specified sites of female genital organs
185 Malignant neoplasm of prostate
188.0 Malignant neoplasm of trigone of urinary bladder
188.1 Malignant neoplasm of dome of urinary bladder
188.2 Malignant neoplasm of lateral wall of urinary bladder
188.3 Malignant neoplasm of anterior wall of urinary bladder
188.4 Malignant neoplasm of posterior wall of urinary bladder
188.5 Malignant neoplasm of bladder neck
188.6 Malignant neoplasm of ureteric orifice
188.8 Malignant neoplasm of other specified sites of bladder
189.3 Malignant neoplasm of urethra
197.5 Secondary malignant neoplasm of large intestine and rectum
198.1 Secondary malignant neoplasm of other urinary organs
198.6 Secondary malignant neoplasm of ovary
198.82 Secondary malignant neoplasm of genital organs
199.0 Disseminated malignant neoplasm

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOMReferences
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCIVersion 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection

**Coding Tips**
This anesthesia service is provided when the surgeon performs a tubal ligation/transection indicated by one of the following CPT surgical codes: 58600, 58605, 58615, 58670, and 58671. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. Medicare and many other payers will provide benefits for a tubal ligation or transection only when sterilization is a necessary part of the treatment of an illness or injury (e.g., removal of a uterus because of a tumor or the removal of diseased ovaries [bilateral oophorectomy]). However, benefits are most often denied when the procedure is performed to prevent conception by sterilization. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers. Code V25.2 Sterilization, may be a first listed diagnosis.

**Terms To Know**
- **Antepartum.** Period of pregnancy between conception and the onset of labor.
- **Fallopian tubes.** Bilateral, paired tubes that extend from the uterus to the ovaries, through which an ovum released from the follicle travels to the uterus during ovulation.
- **Ligation.** Tying off a blood vessel or duct with a suture or a soft, thin wire.
- **Medically necessary.** Services or supplies that are warranted for the diagnosis or treatment of a medical condition; are used for diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not solely for the convenience of the patient or the doctor.
- **Multiparity.** Condition of having had two or more pregnancies that resulted in viable fetuses; producing more than one fetus or offspring in the same gestation.
- **Oclusion.** Constriction, closure, or blockage of a passage.
- **Postpartum.** Period of time following childbirth.
- **Transsection.** Transverse dissection; to cut across a long axis; cross section.

**Surgical to Anesthesia Code Crosswalk**
58600, 58605, 58615, 58670, 58671

**ICD-9-CM Diagnostic Codes**
- 659.41 Grand multiparity, delivered, with or without mention of antepartum condition
- V25.2 Sterilization
- V61.5 Multiparity

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**
100-3, 230.3

**CCI Version 20.0**

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00860

00860  Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified

Coding Tips
See also codes in the 00840-00851 range. For anesthesia during procedures on the upper abdomen, see codes 00700-00797. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- calculus: Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.
- hyperplasia: Abnormal proliferation in the number of normal cells in regular tissue arrangement.
- obstruction: Blockage that prevents normal function of the valve or structure.
- prolapse: Falling, sliding, or sinking of an organ from its normal location in the body.
- rupture: Tearing or breaking open of tissue.
- stricture: Narrowing of an anatomical structure.
- vesical fistula: Abnormal communication between the bladder and another stricture.

Surgical to Anesthesia Code Crosswalk
38562, 38564, 38570, 38571, 38572, 38760, 38765, 38770, 38780, 49060, 49411, 50021, 50200, 50290, 50382, 50384, 50387, 50390, 50392, 50393, 50395, 50397, 50398, 50399, 50491, 50520, 50575, 50576, 50578, 50580, 50620, 50630, 50650, 50688, 50722, 50727, 50728, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50823, 50830, 50860, 50900, 50920, 50930, 50940, 50945, 50947, 50948, 50970, 50972, 50974, 50976, 50978, 50980, 51020, 51030, 51040, 51045, 51060, 51065, 51080, 51100, 51200, 51250, 51300, 51350, 51500, 51550, 51650, 51800, 51820, 51840, 51841, 51845, 51860, 51865, 51880, 51900, 51920, 51925, 51940, 51980, 51990, 51992, 52100, 53431, 53440, 53442, 53445, 53446, 53447, 53448, 53449, 53490, 53450, 53560, 53565, 53586, 53585, 53724, 57284, 57287, 57288, 57308, 57330, 57423, 57425, 57815

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
cauda equina. Spinal roots occupying the lower end of the vertebral canal and descending from the distal end of the spinal cord, named for their appearance resembling that of the tail of a horse.
donor. Person from whom tissues or organs are removed for transplantation.
nephrectomy. Partial or total removal of the kidney.
ephritis. Inflammation of the kidney, often due to infection, metabolic disorder, or an autoimmune process.
nephronorrhaphy. Open surgical repair or suture of a wound or injury of the kidney.
peristalsis. Smooth muscle action of automatic contractions that propel substances through the body, such as urine into the bladder and food through the digestive tract.
ureter. Tube leading from the kidney to the urinary bladder made up of three layers of tissue: the mucous lining of the inner layer; the smooth, muscular middle layer that propels the urine from the kidney to the bladder by peristalsis; and the outer layer made of fibrous connective tissue. Each ureter leaves the kidney from the hilum, a concave notch on the middle surface, and enters the bladder through a narrow valve-like orifice that prevents the backflow of urine to the kidney.
vesicoureteral reflux. Urine passage from the bladder back up into the ureter and kidneys that can lead to bacterial infection and an increase in hydrostatic pressure, causing kidney damage.

Surgical to Anesthesia Code Crosswalk
0135T, 50010, 50020, 50045, 50060, 50065, 50070, 50075, 50080, 50081, 50120, 50125, 50130, 50135, 50205, 50220, 50225, 50228, 50230, 50234, 50236, 50240, 50250, 50280, 50320, 50340, 50370, 50387, 50400, 50405, 50500, 50525, 50540, 50541, 50542, 50543, 50544, 50545, 50546, 50547, 50548, 50551, 50553, 50555, 50557, 50562, 50570, 50572, 50574, 50592, 50593, 50600, 50605, 50610, 50660, 50700, 50715, 50725, 50740, 50750, 50760, 50770, 50810, 50830, 50840, 52356

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; total cystectomy

Coding Tips

This anesthesia service is provided when the surgeon removes all or part of the urinary bladder as indicated by surgical codes 51570, 51575, 51580, 51585, 51590, 51595, and 51596. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

cystectomy. 1) Excision or removal of the urinary bladder. 2) Excision or removal of a cyst on any anatomical site.

Surgical to Anesthesia Code Crosswalk

51570, 51575, 51580, 51585, 51590, 51595, 51596

ICD-9-CM Diagnostic Codes

153.9 Malignant neoplasm of colon, unspecified site
185 Malignant neoplasm of prostate
187.8 Malignant neoplasm of other specified sites of male genital organs
187.9 Malignant neoplasm of male genital organ, site unspecified
188.0 Malignant neoplasm of trigone of urinary bladder
188.1 Malignant neoplasm of dome of urinary bladder
188.2 Malignant neoplasm of lateral wall of urinary bladder
188.3 Malignant neoplasm of anterior wall of urinary bladder
188.4 Malignant neoplasm of posterior wall of urinary bladder
188.8 Malignant neoplasm of other specified sites of bladder
188.9 Malignant neoplasm of bladder, part unspecified
196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
198.1 Secondary malignant neoplasm of other urinary organs
236.7 Neoplasm of uncertain behavior of bladder
236.99 Neoplasm of uncertain behavior of other and unspecified urinary organs
239.4 Neoplasm of unspecified nature of bladder
239.5 Neoplasm of unspecified nature of other genitourinary organs
595.1 Chronic interstitial cystitis — (Use additional code to identify organism, such as E. coli: 041.41-041.49)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,4,120.1; 100-4,4,120.3; 100-4,4,120.3.3; 100-4,4,120.4; 100-4,4,120.4.2; 100-4,4,120.4.3; 100-4,4,120.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; radical prostatectomy (suprapubic, retropubic)

Coding Tips
This anesthesia service is provided when the surgeon performs a radical prostatectomy. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
55821, 55831, 55840, 55842, 55845, 55866

ICD-9-CM Diagnostic Codes
185 Malignant neoplasm of prostate
196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
198.82 Secondary malignant neoplasm of genital organs
222.2 Benign neoplasm of prostate
233.4 Carcinoma in situ of prostate
236.5 Neoplasm of uncertain behavior of prostate
239.5 Neoplasm of unspecified nature of other genitourinary organs
600.00 Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptoms [LUTS]
600.01 Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms [LUTS] — (Use additional code to identify symptoms: 599.69, 788.20, 788.21, 788.30-788.39, 788.41, 788.43, 788.62, 788.63, 788.64, 788.65)
600.10 Nodular prostate without urinary obstruction
600.11 Nodular prostate with urinary obstruction
600.20 Benign localized hyperplasia of prostate without urinary obstruction and other lower urinary tract symptoms [LUTS]
600.21 Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms [LUTS] — (Use additional code to identify symptoms: 599.69, 788.20, 788.21, 788.30-788.39, 788.41, 788.43, 788.62, 788.63, 788.64, 788.65)
600.3 Cyst of prostate
600.91 Hyperplasia of prostate, unspecified, with urinary obstruction and other lower urinary tract symptoms [LUTS] — (Use additional code to identify symptoms: 599.69, 788.20, 788.21, 788.30-788.39, 788.41, 788.43, 788.62, 788.63, 788.64, 788.65)
601.0 Acute prostatitis — (Use additional code to identify organism: 041.0, 041.1)
601.1 Chronic prostatitis — (Use additional code to identify organism: 041.0, 041.1)
601.2 Abscess of prostate — (Use additional code to identify organism: 041.0, 041.1)
601.3 Prostatocystitis — (Use additional code to identify organism: 041.0, 041.1)
601.4 Prostatitis in diseases classified elsewhere — (Use additional code to identify organism: 041.0, 041.1. Code first underlying disease: 016.5, 039.8, 095.8, 116.0)
602.0 Calculus of prostate
602.2 Atrophy of prostate
602.3 Dysplasia of prostate
602.8 Other specified disorder of prostate
V64.41 Laparoscopic surgical procedure converted to open procedure

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**00866**

**Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; adrenalectomy**

### Coding Tips

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

### Terms To Know

- adrenal gland. Specialized group of secretory cells located above the kidneys that produce hormones that regulate the metabolism, maintain fluid balance, and control blood pressure. The adrenal glands also produce slight amounts of androgens, estrogens, and progesterone.

### Surgical to Anesthesia Code Crosswalk

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<td>60545</td>
<td>Malignant neoplasm of renal pelvis</td>
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<td>60650</td>
<td>Malignant neoplasm of adrenal gland</td>
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### ICD-9-CM Diagnostic Codes

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<td>Malignant neoplasm of renal pelvis</td>
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<td>197.6</td>
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<td>Neoplasm of uncertain behavior of adrenal gland — (Use additional code to identify any functional activity)</td>
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<td>Neoplasm of unspecified nature of digestive system</td>
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### Procedure Codes

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Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient)

Coding Tips
This code represents anesthesia during renal transplant as described by surgery codes 50360, 50365, and 50380, and code S2065 for non-Medicare beneficiaries. See the Surgical to Anesthesia Crosswalk for a complete list of the surgery codes associated with this anesthesia service. For anesthesia for a living donor nephrectomy, see code 00862. When the kidney is harvested from a brain-dead patient, see code 01990. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
donor. Person from whom tissues or organs are removed for transplantation.
ESRD. End stage renal disease. Progression of chronic renal failure to lasting and irreparable kidney damage that requires dialysis or renal transplant for survival.
nephritis. Inflammation of the kidney, often due to infection, metabolic disorder, or an autoimmune process.
nephrotic syndrome. Condition where levels of albumin in the blood and urine are far below the norm.
renal. Referring to the kidney.
transplant. Insertion of an organ or tissue from one person or site into another.

Surgical to Anesthesia Code Crosswalk
50360, 50365, 50380, S2065

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10,4; 100-4,4,10,5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,4,12,140.3; 100-4,4,12,140.3.3; 100-4,4,12,140.3.4; 100-4,4,12,140.4; 100-4,4,12,140.4.1; 100-4,4,12,140.4.2; 100-4,4,12,140.4.3; 100-4,4,12,140.4.4

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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<td>Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal transplant (recipient)</td>
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Coding and Payment Guide for Anesthesia Services
Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy

Coding Tips
This anesthesia service is provided when the surgeon performs a cystolithotomy as indicated by surgical code 51050. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
-otomy. Indicates a cutting.
calculus. Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.
cyst(o)-. Relating to the urinary bladder or a cyst.
cystostomy. Formation of an opening through the abdominal wall into the bladder.
cystotomy. Surgical incision into the gallbladder or urinary bladder.
lith(o)-. Relating to a hard or calcified substance.
urethra. Small tube lined with mucous membrane that leads from the bladder to the exterior of the body. In the male, it is approximately 20 cm long and passes through the prostate gland just below the bladder, where it joins the ejaculatory ducts. Urine is prevented from mixing with semen during ejaculation by the reflex closure of the sphincter muscles guarding the opening into the bladder. In the female, the urethra lies directly behind the symphysis pubis and in front of the vagina, and is only about 3 cm long.

Surgical to Anesthesia Code Crosswalk
51050

ICD-9-CM Diagnostic Codes
594.1 Other calculus in bladder
594.2 Calculus in urethra
594.8 Other lower urinary tract calculus
594.9 Unspecified calculus of lower urinary tract

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

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Anesthesia for lithotripsy, extracorporeal shock wave; with water bath

00872 without water bath

**Coding Tips**

This anesthesia service is provided when the surgeon performs extracorporeal shock wave lithotripsy as indicated by surgical code 50590. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. Correct code assignment is dependent upon use of water bath. Report code 00872 when water bath is not used; code 00873 when water bath is used. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

**calculus.** Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.

**extracorporeal.** Located or taking place outside the body.

**hematuria.** Blood in urine, which may present as gross visible blood or as the presence of red blood cells visible only under a microscope. Hematuria is reported with an ICD-9-CM code from range 599.70-599.72 or ICD-10-CM subcategory R31. Underlying conditions may include infections, neoplasms, radiation injury, calculi, kidney disease, genitourinary trauma, systemic disorders, and adverse effects of anticoagulant therapy. Hemoglobinuria (791.2) is excluded. Hematuria due to specified infectious diseases is coded to the disease within that chapter. **Synonym(s):** hemuresis.

**lithotripsy.** Destruction of calcified substances in the gallbladder or urinary system by smashing the concretion into small particles to be washed out. This may be done by surgical or noninvasive methods, such as ultrasound.

**staghorn calculus.** Renal stone that develops in the pelvicaliceal system, and in advanced cases has a branching appearance that resembles the antlers of a stag.

**ultrasound.** Imaging using ultra-high sound frequency bounced off body structures.

**ureter.** Tube leading from the kidney to the urinary bladder made up of three layers of tissue: the mucous lining of the inner layer; the smooth, muscular middle layer that propels the urine from the kidney to the bladder by peristalsis; and the outer layer made of fibrous connective tissue. Each ureter leaves the kidney from the hilum, a concave notch on the middle surface, and enters the bladder through a narrow valve-like orifice that prevents the backflow of urine to the kidney.

**Surgical to Anesthesia Code Crosswalk**

50590

**ICD-9-CM Diagnostic Codes**

588.81 Secondary hyperparathyroidism (of renal origin)

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for procedures on major lower abdominal vessels; not otherwise specified

Coding Tips
See also code 00770. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.
atherosclerosis. Buildup of yellowish plaques composed of cholesterol and lipoid material within the arteries.
blood vessel. Tubular channel consisting of arteries, veins, and capillaries that transports blood throughout the body.
congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
dissection. Separating by cutting tissue or body structures apart.
embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.
fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
gangrene. Death of tissue, usually resulting from a loss of vascular supply, followed by a bacterial attack or onset of disease.
ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.
necrosis. Death of cells or tissue within a living organ or structure. Appropriate ICD-9-CM diagnosis code selection is dependent upon anatomical site.
stricture. Narrowing of an anatomical structure.
thrombectomy. Removal of a clot (thrombus) from a blood vessel utilizing various methods. Code assignment depends upon site and method.
thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.
vena cava. Main venous trunk that empties into the right atrium from both the lower and upper regions, beginning at the junction of the common iliac veins inferiorly and the two brachiocephalic veins superiorly.

Surgical to Anesthesia Code Crosswalk
0001T, 0002T, 0338T, 0339T, 34401, 34820, 34830, 34831, 34832, 34833, 35102, 35103, 35131, 35132, 35182, 35189, 35311, 35355, 35454, 35482, 35491, 35492, 35537, 35538, 35539, 35540, 35541, 35546, 35548, 35549, 35551, 35556, 35565, 35566, 35637, 35638, 35641, 35646, 35647, 35651, 35663, 35665, 35761, 36245, 36246, 36247, 36251, 36252, 36253, 36254, 37210, 37220, 37221, 37620, 37660, 50100

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00880-00882
Anesthesia for; anorectal procedure

Coding Tips
This code should not be used for endoscopic surgeries. For anesthesia provided at the time of a lower endoscopic procedure, see code 00810. For procedures on perineal skin, muscles, and/or nerves, see codes 00300 and 00400. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

colitis. Inflammation of the colon, caused by an infection or external influences such as laxatives, radiation, or antibiotics. Diagnosis codes are selected by cause or type.

colitis. Deep furrow, groove, or cleft in tissue structures.

fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.

ileus. Persistent obstruction of the intestines coded in different chapters in ICD-9-CM based on its type or cause, location, and whether it occurs in a newborn.

intussusception. Prolapse of one section of intestine into the lumen of an adjacent section of the bowel that occurs mainly in children and causes pain, vomiting, and mucus passed from the rectum and requires surgical intervention.

megacolon. Enlargement or dilation of the large intestines or the colon.

megacolon. Enlargement or dilation of the large intestines, commonly caused by the use of drugs that slow intestinal motility, such as narcotic pain medications, or a disease process, such as ulcerative colitis. This condition is reported with ICD-9-CM code 564.7.

megacolon. Congenital enlargement or dilation of the colon, with the absence of nerve cells in a segment of colon distally that causes the inability to defecate. This disease is reported with ICD-9-CM code 751.3.

neurogenic. Originating in or related to the nervous system.

polypl. Small growth on a stalk-like attachment projecting from a mucous membrane.

prolapse. Falling, sliding, or sinking of an organ from its normal location in the body.

volvulus. Twisting, knotting, or entanglement of the bowel on itself that may quickly compromise oxygen supply to the intestinal tissues. A volvulus usually occurs at the sigmoid and ileocecal areas of the intestines.

Surgical to Anesthesia Code Crosswalk

| Code 00902 | Anesthesia for; anorectal procedure |

ICD-9-CM Diagnostic_codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,4,12,140.1; 100-4,4,12,140.3; 100-4,4,12,140.3.4; 100-4,4,12,140.4.1; 100-4,4,12,140.4.2; 100-4,4,12,140.4.3; 100-4,4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Coding and Payment Guide for Anesthesia Services

Procedure Codes

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for; radical perineal procedure

**Coding Tips**

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**

45123, 46716, 46730, 46740, 46742, 46744, 46746, 46748, 55810, 55812, 55815, 55970, 56630, 56631, 56632, 56633, 56634, 56637, 56640, 57109, 57111, 57112, 57291, 57292, 64774

**ICD-9-CM Diagnostic Codes**

- Malignant neoplasm of rectosigmoid junction 154.0
- Malignant neoplasm of rectum 154.1
- Malignant neoplasm of anus, unspecified site 154.3
- Malignant neoplasm of connective and other soft tissue of pelvis 171.6
- Malignant melanoma of skin of trunk, except scrotum 172.5
- Unspecified malignant neoplasm of skin of trunk, except scrotum 173.50
- Basal cell carcinoma of skin of trunk, except scrotum 173.51
- Squamous cell carcinoma of skin of trunk, except scrotum 173.52
- Malignant neoplasm of vagina 184.0
- Malignant neoplasm of vulva, unspecified site 184.4
- Malignant neoplasm of prostate 185
- Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb 196.5
- Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes 196.6
- Benign neoplasm of genital organs 221.1
- Carcinoma in situ of rectum 230.4
- Carcinoma in situ, vagina 233.32
- Carcinoma in situ, vulva 233.34
- Carcinoma in situ of prostate 302.51
- Trans-sexualism with asexual history 302.52
- Trans-sexualism with homosexual history 302.53
- Trans-sexualism with heterosexual history 302.6
- Gender identity disorder in children 555.1
- Gender identity disorder in adolescents or adults 555.2
- Ulcerative (chronic) enterocolitis 556.0
- Ulcerative (chronic) proctitis 556.2

**Procedure Codes**

- 601.0 Acute prostatitis — (Use additional code to identify organism: 041.0, 041.1)
- 601.1 Chronic prostatitis — (Use additional code to identify organism: 041.0, 041.1)
- 601.2 Abscess of prostate — (Use additional code to identify organism: 041.0, 041.1)
- 601.3 Prostatocystitis — (Use additional code to identify organism: 041.0, 041.1)
- 602.0 Calculus of prostate
- 602.2 Atrophy of prostate
- 602.3 Dysplasia of prostate
- 752.41 Embryonic cyst of cervix, vagina, and external female genitalia
- 752.7 Indeterminate sex and pseudohermaphroditism
- 959.19 Other injury of other sites of trunk
- 951.8 Other aftercare involving the use of plastic surgery

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for vulvectomy

**Coding Tips**

This anesthesia service is provided when the surgeon performs vulvectomy procedures as indicated by surgical codes 56620 and 56625. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

vulvectomy. Surgical removal of all or part of the vulva, often performed to treat malignant or premalignant lesions. Lymph nodes may be removed at the same surgical session.

**Surgical to Anesthesia Code Crosswalk**

56620, 56625, 64774

**ICD-9-CM Diagnostic Codes**

171.6  Malignant neoplasm of connective and other soft tissue of pelvis
172.5  Malignant melanoma of skin of trunk, except scrotum
173.50  Unspecified malignant neoplasm of skin of trunk, except scrotum
173.51  Basal cell carcinoma of skin of trunk, except scrotum
173.52  Squamous cell carcinoma of skin of trunk, except scrotum
173.59  Other specified malignant neoplasm of skin of trunk, except scrotum
184.2  Malignant neoplasm of vulva, unspecified site
198.82  Secondary malignant neoplasm of genital organs
199.1  Other malignant neoplasm of unspecified site
221.2  Benign neoplasm of vulva
233.30  Carcinoma in situ, unspecified female genital organ
233.31  Carcinoma in situ, vagina
233.32  Carcinoma in situ, vulva
233.39  Carcinoma in situ, other female genital organ
236.3  Neoplasm of uncertain behavior of other and unspecified female genital organs
237.70  Neurofibromatosis, unspecified
239.5  Neoplasm of unspecified nature of other genitourinary organs
356.4  Idiopathic progressive polyneuropathy
616.4  Other abscess of vulva — (Use additional code to identify organism: 041.00-041.09, 041.10-041.19)
623.0  Dysplasia of vagina
624.3  Hypertrophy of labia
624.8  Other specified noninflammatory disorder of vulva and perineum
698.1  Pruritus of genital organs
701.0  Circumscribed scleroderma
752.40  Unspecified congenital anomaly of cervix, vagina, and external female genitalia
752.41  Embryonic cyst of cervix, vagina, and external female genitalia
752.49  Other congenital anomaly of cervix, vagina, and external female genitalia
752.89  Other specified anomalies of genital organs
752.9  Unspecified congenital anomaly of genital organs
782.2  Localized superficial swelling, mass, or lump
V84.09  Genetic susceptibility to other malignant neoplasm — (Use additional code, if applicable, for any associated family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

Please note that these CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<td>00906</td>
<td>Anesthesia for; vulvectomy</td>
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<tr>
<td>00906</td>
<td>Coding Tips</td>
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<tr>
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<td>Terms To Know</td>
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Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
SS801, 64774

ICD-9-CM Diagnostic Codes

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<td>Malignant neoplasm of prostate</td>
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<tr>
<td>198.82</td>
<td>Secondary malignant neoplasm of genital organs</td>
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<tr>
<td>222.2</td>
<td>Benign neoplasm of prostate</td>
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<td>233.4</td>
<td>Carcinoma in situ of prostate</td>
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<td>236.5</td>
<td>Neoplasm of uncertain behavior of prostate</td>
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<tr>
<td>237.70</td>
<td>Neurofibromatosis, unspecified</td>
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<tr>
<td>239.5</td>
<td>Neoplasm of unspecified nature of other genitourinary organs</td>
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<tr>
<td>356.4</td>
<td>Idiopathic progressive polyneuropathy</td>
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<tr>
<td>600.00</td>
<td>Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptoms [LUTS]</td>
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<td>Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms [LUTS] — (Use additional code to identify symptoms: 599.69, 788.20, 788.21, 788.30-788.39, 788.41, 788.43, 788.62, 788.63, 788.64, 788.65)</td>
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<td>Nodular prostate without urinary obstruction</td>
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<td>600.11</td>
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<td>600.20</td>
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<td>Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms [LUTS] — (Use additional code to identify symptoms: 599.69, 788.20, 788.21, 788.30-788.39, 788.41, 788.43, 788.62, 788.63, 788.64, 788.65)</td>
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<td>Hyperplasia of prostate, unspecified, with urinary obstruction and other lower urinary tract symptoms [LUTS] — (Use additional code to identify symptoms: 599.69, 788.20, 788.21, 788.30-788.39, 788.41, 788.43, 788.62, 788.63, 788.64, 788.65)</td>
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<td>Acute prostatitis — (Use additional code to identify organism: 041.0, 041.1)</td>
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<td>Prostatocystitis — (Use additional code to identify organism: 041.0, 041.1)</td>
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<td>601.4</td>
<td>Prostatitis in diseases classified elsewhere — (Use additional code to identify organism: 041.0, 041.1. Code first underlying disease: 016.5, 039.8, 095.8, 116.0)</td>
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<td>Other specified inflammatory disease of prostate — (Use additional code to identify organism: 041.0, 041.1)</td>
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<td>602.2</td>
<td>Atrophy of prostate</td>
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<tr>
<td>602.3</td>
<td>Dysplasia of prostate</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00910-00918
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

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
atresia. Congenital closure or absence of a tubular organ or an opening to the body surface.
calculus. Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.
calculus. Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.
cystocele. Herniation of the bladder into the vagina.
detrusor sphincter dyssynergia. Condition in which urinary outflow is obstructed because the bladder neck fails to relax or tightens when the detrusor muscle contracts during urination.
fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.
hematuria. Blood in urine, which may present as gross visible blood or as the presence of red blood cells visible only under a microscope.
hydroureter. Abnormal enlargement or distension of the ureter with water or urine caused by an obstruction.
pyeloureteritis cystica. Inflammation and formation of many small fluid-filled submucosal cysts in the ureter and renal pelvis. Most commonly affected individuals are between the ages of 50-60, with a small predominance of females.
resection. Surgical removal of a part or all of an organ or body part.
stenosis. Narrowing or constriction of a passage.
stricture. Narrowing of an anatomical structure.
trans. Transverse.
ureter. Tube leading from the kidney to the urinary bladder made up of three layers of tissue: the mucous lining of the inner layer; the smooth, muscular middle layer that propels the urine from the kidney to the bladder by peristalsis; and the outer layer made of fibrous connective tissue. Each ureter leaves the kidney from the hilum, a concave notch on the middle surface, and enters the bladder through a narrow valve-like oriﬁce that prevents the backflow of urine to the kidney.
urethra. Small tube lined with mucous membrane that leads from the bladder to the exterior of the body.

Surgical to Anesthesia Code Crosswalk

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00920

00920  Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
hydrocele. Serous fluid that collects in the tunica vaginalis, the spermatic cord, or the canal of Nuck. Hydroceles may be congenital, due to a defect in the tunica vaginalis, or secondary, due to fluid accumulation, injury, infection, or radiotherapy.

hypertrophy. Abnormal proliferation in the number of normal cells in regular tissue arrangement.

phimosis. Condition in which the foreskin is contracted and cannot be drawn back behind the glans penis.

prostate. Male gland surrounding the bladder neck and urethra that secretes a substance into the seminal fluid.

urethra. Small tube lined with mucous membrane that leads from the bladder to the exterior of the body. In the male, it is approximately 20 cm long and passes through the prostate gland just below the bladder, where it joins the ejaculatory ducts. Urine is prevented from mixing with semen during ejaculation by the reflex closure of the sphincter muscles guarding the opening into the bladder. In the female, the urethra lies directly behind the symphysis pubis and in front of the vagina, and is only about 3 cm long.

varices. Enlarged, dilated, or twisted, turning veins.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,4,120.1; 100-4,4,120.3; 100-4,4,120.3.3; 100-4,4,120.4; 100-4,4,120.4.2; 100-4,4,120.4.3; 100-4,4,120.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral seminal vesicles

Coding Tips
Medicare and many other payers will provide benefits only when sterilization is a necessary part of the treatment of an illness or injury, e.g., bilateral orchidectomy in a case of cancer of the prostate. However, benefits are most often denied when the procedure is performed to prevent conception by sterilization. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
**seminal vesicles.** Paired glands located at the base of the bladder in males that release the majority of fluid into semen through ducts that join with the vas deferens forming the ejaculatory duct.

**vasectomy.** Surgical procedure involving the removal of all or part of the vas deferens, usually performed for sterilization or in conjunction with a prostatectomy. When performed separately, report CPT code 55250.

Surgical to Anesthesia Code Crosswalk
55250, 55600, 55605, 55650, 55680

ICD-9-CM Diagnostic Codes
187.8 Malignant neoplasm of other specified sites of male genital organs
198.82 Secondary malignant neoplasm of genital organs
222.8 Benign neoplasm of other specified sites of male genital organs
233.6 Carcinoma in situ of other and unspecified male genital organs
236.6 Neoplasm of uncertain behavior of other and unspecified male genital organs
239.5 Neoplasm of unspecified nature of other genitourinary organs
608.0 Seminal vesiculitis — (Use additional code to identify organism)
608.82 Hematospermia
608.83 Specified vascular disorder of male genital organs
608.85 Stricture of male genital organs
608.89 Other specified disorder of male genital organs
752.89 Other specified anomalies of genital organs
V25.2 Sterilization

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Also not with 00922: 99466, 99485

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
00924

00924  Anesthesia for procedures on male genitalia (including open urethral procedures); undescended testis, unilateral or bilateral

Coding Tips
This procedure code is reported once regardless of whether or not the surgical procedure is performed unilaterally or bilaterally. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bilateral. Consisting of or affecting two sides.
epididymis. Coiled tube on the back of the testis that is the site of sperm maturation and storage and where spermatozoa are propelled into the vas deferens toward the ejaculatory duct by contraction of smooth muscle.
retractile. Capable of being drawn back. r. testis Congenital condition in which the testicle is located near the groin or high in the scrotum, although it can move down into the scrotum at times. Surgery is rarely required, although the condition may be treated with chorionic gonadotropin to encourage complete descent of the testicles. This condition is reported with ICD-9-CM code 752.52. Synonym(s): hypermobile testis.
scrotum. Skin pouch that holds the testes and supporting reproductive structures.
seminal vesicles. Paired glands located at the base of the bladder in males that release the majority of fluid into semen through ducts that join with the vas deferens forming the ejaculatory duct.
testes. Male gonadal paired glands located in the scrotum that secrete testosterone and contain the seminiferous tubules where sperm is produced.
transposition. Removal or exchange from one side to another; change of position from one place to another.
unilateral. Located on or affecting one side.

Surgical to Anesthesia Code Crosswalk
54550

ICD-9-CM Diagnostic Codes
752.51  Undescended testis
752.52  Retractile testis
752.81  Scrotal transposition

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Fac Total  Non-Fac Total  Malpractice  Fac PEN  Non-Fac PE  Work Value  Base Unit
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Anesthesia for procedures on male genitalia (including open urethral procedures); radical orchiectomy, inguinal

**Coding Tips**

Appropriate code selection is dependent upon surgical approach. Select code 00926 for inguinal approach; code 00928 for abdominal approach. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- **epididymis**: Coiled tube on the back of the testis that is the site of sperm maturation and storage and where spermatozoa are propelled into the vas deferens toward the ejaculatory duct by contraction of smooth muscle.
- **inguinal**: Within the groin region.
- **orchiectomy**: Surgical removal of one or both testicles via a scrotal or groin incision, indicated in cases of cancer, traumatic injury, and sex reassignment surgery.
- **radical**: Extensive surgery.
- **testes**: Male gonadal paired glands located in the scrotum that secrete testosterone and contain the seminiferous tubules where sperm is produced.

**Surgical to Anesthesia Code Crosswalk**

54530, 54535

**ICD-9-CM Diagnostic Codes**

- 186.0  Malignant neoplasm of undescended testis — (Use additional code to identify any functional activity)
- 186.9  Malignant neoplasm of other and unspecified testis — (Use additional code to identify any functional activity)
- 187.5  Malignant neoplasm of epididymis
- 187.8  Malignant neoplasm of other specified sites of male genital organs
- 198.82 Secondary malignant neoplasm of genital organs
- 233.6  Carcinoma in situ of other and unspecified male genital organs
- 236.4  Neoplasm of uncertain behavior of testis — (Use additional code to identify any functional activity)
- 239.5  Neoplasm of unspecified nature of other genitourinary organs
- V64.41 Laparoscopic surgical procedure converted to open procedure

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4.10; 100-4,4.10.5; 100-4,4,250.3.3; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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00930

Anesthesia for procedures on male genitalia (including open urethral procedures); orchiopexy, unilateral or bilateral

Coding Tips
This procedure code is reported once regardless of whether or not the surgical procedure is performed unilaterally or bilaterally. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bilateral. Consisting of or affecting two sides.
epididymis. Coiled tube on the back of the testis that is the site of sperm maturation and storage and where spermatozoa are propelled into the vas deferens toward the ejaculatory duct by contraction of smooth muscle.
gangrene. Death of tissue, usually resulting from a loss of vascular supply, followed by a bacterial attack or onset of disease.
orchiopexy. Surgical fixation of an undescended testicle within the scrotum.

Synonym(s): orchidopexy.

retractile. Capable of being drawn back. r. testis Congenital condition in which the testicle is located near the groin or high in the scrotum, although it can move down into the scrotum at times. Surgery is rarely required, although the condition may be treated with chorionic gonadotropin to encourage complete descent of the testicles. This condition is reported with ICD-9-CM code 752.52.

Synonym(s): hypermobile testis.
sample. Skin pouch that holds the testes and supporting reproductive structures.
testes. Male gonadal paired glands located in the scrotum that secrete testosterone and contain the seminiferous tubules where sperm is produced.
torsion of testis. Twisting, turning, or rotation of the testicle upon itself, so as to compromise or cut off the blood supply.

transposition. Removal or exchange from one side to another; change of position from one place to another.

unilateral. Located on or affecting one side.

Surgical to Anesthesia Code Crosswalk
54600, 54620, 54640, 54650

ICD-9-CM Diagnostic Codes
550.90 Inguinal hernia without mention of obstruction or gangrene, unilateral or unspecified, (not specified as recurrent)
608.20 Torsion of testis, unspecified
608.21 Extravaginal torsion of spermatic cord
608.22 Intravaginal torsion of spermatic cord
608.23 Torsion of appendix testis
608.24 Torsion of appendix epididymis
608.89 Other specified disorder of male genital organs
752.51 Undescended testis
752.52 Retractile testis
752.81 Scrotal transposition
752.89 Other specified anomalies of genital organs
V64.41 Laparoscopic surgical procedure converted to open procedure

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,10.4; 100-4,10.5; 100-4,250.3.2; 100-4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for procedures on male genitalia (including open urethral procedures); complete amputation of penis

- 00932
  - radical amputation of penis with bilateral inguinal lymphadenectomy

- 00934
  - radical amputation of penis with bilateral inguinal and iliac lymphadenectomy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- amputation. Removal of all or part of a limb or digit through the shaft or body of a bone.
- inguinal. Within the groin region.
- lymphadenectomy. Dissection of lymph nodes free from the vessels and removal for examination by frozen section in a separate procedure to detect early-stage metastases.
- penis. Male reproductive and urinary excretion organ, the body of which is composed of three structures enclosed by fascia and skin: two parallel cylindrical bodies—the corpora cavernosa—and the corpus spongiosum lying underneath them, through which the urethra passes.

Surgical to Anesthesia Code Crosswalk
54125, 54130, 54135

ICD-9-CM Diagnostic Codes

187.1 Malignant neoplasm of prepuce
187.2 Malignant neoplasm of glans penis
187.3 Malignant neoplasm of body of penis
187.4 Malignant neoplasm of penis, part unspecified
187.9 Malignant neoplasm of male genital organ, site unspecified
196.2 Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5 Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
198.82 Secondary malignant neoplasm of genital organs
198.89 Secondary malignant neoplasm of other specified sites
222.1 Benign neoplasm of penis
233.5 Carcinoma in situ of penis
236.6 Neoplasm of uncertain behavior of other and unspecified male genital organs
878.0 Open wound of penis, without mention of complication

Coding and Payment Guide for Anesthesia Services

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach)

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
S4400, S4401, S4402, S4405, S4407, S4409, S4410, S4411, S4416, S4417

ICD-9-CM Diagnostic Codes
249.60 Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified — (Use additional code to identify manifestation: 337.1, 353.5, 354.0-355.9, 357.2, 536.3, 713.5) (Use additional code to identify any associated insulin use: V58.67)
249.61 Secondary diabetes mellitus with neurological manifestations, uncontrolled — (Use additional code to identify manifestation: 337.1, 353.5, 354.0-355.9, 357.2, 536.3, 713.5) (Use additional code to identify any associated insulin use: V58.67)
250.60 Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled — (Use additional code to identify manifestation: 337.1, 353.5, 354.0-355.9, 357.2, 536.3, 713.5)
250.61 Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 337.1, 353.5, 354.0-355.9, 357.2, 536.3, 713.5)
250.70 Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)
250.71 Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)
257.2 Other testicular hypofunction
302.72 Psychosexual dysfunction with inhibited sexual excitement
337.1 Peripheral autonomic neuropathy in disorders classified elsewhere — (Code first underlying disease: 249.6, 250.6, 277.30-277.39)
600.00 Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptoms [LUTS]
600.10 Nodular prostate without urinary obstruction

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### Terms To Know

- **Bartholin's gland abscess.** Pocket of pus and surrounding cellulitis caused by infection of the Bartholin’s gland and causing localized swelling and pain in the posterior labia majora that may extend into the lower vagina.
- **Colporrhaphy.** Plastic repair or reconstruction of the vagina by suturing the vaginal wall and surrounding fibrous tissue.
- **Dysplasia.** Abnormality or alteration in the size, shape, and organization of cells from their normal pattern of development.
- **Hyster(o)-.** Relating to either the womb or hystera.
- **Leiomyoma.** Benign tumor consisting of smooth muscle in the uterus.
- **Leukoplakia.** Thickened white patches or lesions appearing on a mucous membrane.
- **Vaginectomy.** Surgical excision of all or a portion of the vagina.

### Surgical to Anesthesia Code Crosswalk

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### ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); cervical cerclage

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
cerclage. Looping or encircling an organ or tissue with wire or ligature for positional support.
cervical. Relation to the cervical spine or to the cervix.

Surgical to Anesthesia Code Crosswalk
57700, 59320

ICD-9-CM Diagnostic Codes
622.3 Old laceration of cervix
622.5 Incompetence of cervix
654.50 Cervical incompetence, unspecified as to episode of care in pregnancy — (Code first any associated obstructed labor, 660.2)
654.53 Cervical incompetence, antepartum condition or complication — (Code first any associated obstructed labor, 660.2)
654.54 Cervical incompetence, postpartum condition or complication — (Code first any associated obstructed labor, 660.2)
654.60 Other congenital or acquired abnormality of cervix, unspecified as to episode of care in pregnancy — (Code first any associated obstructed labor, 660.2)
654.63 Other congenital or acquired abnormality of cervix, antepartum condition or complication — (Code first any associated obstructed labor, 660.2)
654.90 Other and unspecified abnormality of organs and soft tissues of pelvis, unspecified as to episode of care in pregnancy — (Code first any associated obstructed labor, 660.2)
654.93 Other and unspecified abnormality of organs and soft tissues of pelvis, antepartum condition or complication — (Code first any associated obstructed labor, 660.2)
867.4 Uterus injury without mention of open wound into cavity
V23.2 Pregnancy with history of abortion
V23.81 Supervision of high-risk pregnancy of elderly primigravida
V23.82 Supervision of high-risk pregnancy of elderly multigravida
V23.83 Supervision of high-risk pregnancy of young primigravida

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

culdocentesis. Aspiration of fluid from the retrouterine cul-de-sac by puncture of the vaginal vault near the midline between the uterosacral ligaments. Report culdocentesis with CPT code 57020. Synonym(s): colpocentesis.

dysmenorrhea. Painful menstruation that may be primary, or essential, due to prostaglandin production and the onset of menstruation; secondary due to uterine, tubal, or ovarian abnormality or disease; spasmodic arising uterine contractions; or obstructive due to some mechanical blockage or interference with the menstrual flow.

dysplasia. Abnormality or alteration in the size, shape, and organization of cells from their normal pattern of development.

dividement. Lining of the uterus, which thickens in preparation for fertilization. A fertilized ovum embeds into the thickened endometrium. When no fertilization takes place, the endometrial lining sheds during the process of menstruation.

hysterosalpingography. Radiographic pictures taken of the uterus and the fallopian tubes after the injection of a radiopaque dye.

hysteroscopy. Visualization and inspection of the uterus using a fiberoptic endoscope inserted through the vagina and cervical os into the uterine cavity. This may be done for diagnostic purposes alone or included with therapeutic procedures performed at the same time.

multiparity. Condition of having had two or more pregnancies that resulted in viable fetuses; producing more than one fetus or offspring in the same gestation.

Surgical to Anesthesia Code Crosswalk
58340, 58345, 58350, 58555, 58558, 58560, 58561, 58562, 58563, 58565, 99170

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3; 100-4,12,140.1; 100-4,12,140.2; 100-4,12,140.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for bone marrow aspiration and/or biopsy, anterior or posterior iliac crest

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **aspiration**: Drawing fluid out by suction.
- **biopsy**: Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
- **bone marrow**: Soft tissue found filling the cavities of bones. Red bone marrow is a hematopoietic tissue that manufactures various cellular components of blood, such as platelets and red and white blood cells. Yellow marrow consists mostly of fat cells and is found in the medullary cavities of large bones. It may be harvested and transplanted for its progenitor or stem cells in cases of leukemia and other diseases biopsied to help diagnose many diseases of the blood.
- **iliac crest**: Edge of the iliac (hip bone).

Surgical to Anesthesia Code Crosswalk
0263T, 0265T, 20240, 20900, 20982, 38220, 38221, 38230, 38232

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for procedures on bony pelvis

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
aneurysmal bone cyst. Solitary bone lesion that bulges into the periosteum, marked by a calcified rim.

decubitus ulcer. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off caused by continual pressure to a localized area, especially over bony areas, where blood circulation is cut off when a patient lies still for too long without changing position.

fracture types. There are three basic degrees of fracture: type I: a small crack in the bone without displacement; type II: a fracture in which the bone is slightly displaced; type III: a fracture in which there are more than three broken pieces of bone that cannot fit together.

osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

pelvis. Distal anterior portion of the trunk that lies between the hipbones, sacrum, and coccyx bones; the inferior portion of the abdominal cavity.

periostitis. Inflammation of the outer layers of bone.

Surgical to Anesthesia Code Crosswalk
11012, 11044, 15920, 15922, 15933, 15935, 15941, 15945, 15946, 20220, 20240, 20245, 20246, 20560, 20665, 20680, 20694, 20902, 20956, 20970, 20982, 26992, 27065, 27066, 27067, 27070, 27071, 27080, 27146, 27151, 27156, 27158, 27193, 27194, 27200, 27202, 27215, 27216, 27217, 85095, 85102, G0412, G0413, G0414, G0415

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01130

01130  Anesthesia for body cast application or revision

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
body cast. Plaster mold that circumferentially encloses the trunk of the body.
closed fracture. Break in a bone without a concomitant opening in the skin.
contracture. Shortening of muscle or connective tissue.
kyphosis. Abnormal posterior convex curvature of the spine, usually in the thoracic region, resembling a hunchback.
open fracture. Exposed break in a bone, always considered compound due to its high risk of infection from the open wound leading to the fracture.
scoliosis. Congenital condition of lateral curvature of the spine, often associated with other spinal column defects, congenital heart disease, or genitourinary abnormalities. It may also be associated with spinal muscular atrophy, cerebral palsy, or muscular dystrophy.

Surgical to Anesthesia Code Crosswalk
29000, 29010, 29020, 29035, 29040, 29044, 29046, 29305, 29325, 29700, 29715, 29720, 29730, 29740

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01140
01140 Anesthesia for interpelviabdominal (hindquarter) amputation

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
amputation. Removal of all or part of a limb or digit through the shaft or body of a bone.
coccyx. Lowest extremity of the vertebral column, formed by the fusion of three to five rudimentary vertebral segments under the sacrum.
osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.
pelvis. Distal anterior portion of the trunk that lies between the hipbones, sacrum, and coccyx bones.
sacrum. Lower portion of the spine composed of five fused vertebrae designated as S1-S5.
tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

Surgical to Anesthesia Code Crosswalk
27290

ICD-9-CM Diagnostic Codes
170.6  Malignant neoplasm of pelvic bones, sacrum, and coccyx
171.6  Malignant neoplasm of connective and other soft tissue of pelvis
198.5  Secondary malignant neoplasm of bone and bone marrow
200.06 Reticulosarcoma of intrapelvic lymph nodes
200.16 Lymphosarcoma of intrapelvic lymph nodes
730.15 Chronic osteomyelitis, pelvic region and thigh — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
926.12 Crushing injury of buttock — (Use additional code to identify any associated injuries: 800-829, 850.0-854.1, 860.0-869.1)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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01150

01150  Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **amputation.** Removal of all or part of a limb or digit through the shaft or body of a bone.
- **pelvis.** Distal anterior portion of the trunk that lies between the hipbones, sacrum, and coccyx bones.
- **radical.** Extensive surgery.
- **tumor.** Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

Surgical to Anesthesia Code Crosswalk
27049, 27059, 27076, 27077, 27078, 27079, 49215

ICD-9-CM Diagnostic Codes
- 170.6  Malignant neoplasm of pelvic bones, sacrum, and coccyx
- 170.7  Malignant neoplasm of long bones of lower limb
- 171.3  Malignant neoplasm of connective and other soft tissue of lower limb, including hip
- 171.6  Malignant neoplasm of connective and other soft tissue of pelvis
- 172.7  Malignant melanoma of skin of lower limb, including hip
- 195.3  Malignant neoplasm of pelvis
- 198.5  Secondary malignant neoplasm of bone and bone marrow
- 198.89  Secondary malignant neoplasm of other specified sites
- 213.6  Benign neoplasm of pelvic bones, sacrum, and coccyx
- 213.7  Benign neoplasm of long bones of lower limb
- 215.3  Other benign neoplasm of connective and other soft tissue of lower limb, including hip
- 215.6  Other benign neoplasm of connective and other soft tissue of pelvis
- 238.0  Neoplasm of uncertain behavior of bone and articular cartilage
- 238.1  Neoplasm of uncertain behavior of connective and other soft tissue
- 239.2  Neoplasms of unspecified nature of bone, soft tissue, and skin

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
- 100-4,2,140.1; 100-4,140.3; 100-4,140.3.3; 100-4,140.4.1; 100-4,140.4.3; 100-4,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01160
01160 Anesthesia for closed procedures involving symphysis pubis or sacroiliac joint

Coding Tips
For anesthesia performed during open surgical procedures involving the symphysis pubis or sacroiliac joint, see code 01170. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
sacro-. Relating to the sacrum (base of the vertebral column).
symphysis. Joint that unifies two opposed bones by a junction of bony surfaces to a plate of fibrocartilage.

Surgical to Anesthesia Code Crosswalk
0334T, 20694, 20982

ICD-9-CM Diagnostic Codes
170.6 Malignant neoplasm of pelvic bones, sacrum, and coccyx
198.5 Secondary malignant neoplasm of bone and bone marrow
213.6 Benign neoplasm of pelvic bones, sacrum, and coccyx
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
731.3 Major osseous defects — (Code first underlying disease: 170.0-170.9, 730.00-730.29, 733.00-733.09, 733.40-733.49, 996.45)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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01170
01170  Anesthesia for open procedures involving symphysis pubis or sacroiliac joint

Coding Tips
For anesthesia performed during closed procedures of the symphysis pubis or sacroiliac joint, see code 01160. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
closed fracture. Break in a bone without a concomitant opening in the skin.
decubitus ulcer. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off caused by continual pressure to a localized area, especially over bony areas, where blood circulation is cut off when a patient lies still for too long without changing position.
dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.
open fracture. Exposed break in a bone, always considered compound due to its high risk of infection from the open wound leading to the fracture.
sacro-. Relating to the sacrum (base of the vertebral column).
symphysis. Joint that unifies two opposed bones by a junction of bony surfaces to a plate of fibrocartilage.

Surgical to Anesthesia Code Crosswalk
0334T, 11011, 11012, 11044, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 27050, 27065, 27066, 27067, 27070, 27071, 27073, 27217, 27218, 27280, 27282

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250,3,2; 100-4,12,140,1; 100-4,12,140,3; 100-4,12,140,3,3; 100-4,12,140,3,4; 100-4,12,140,4,1; 100-4,12,140,4,2; 100-4,12,140,4,3; 100-4,12,140,4,4

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Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
acetabulum. Cup-shaped socket in the hipbone into which the head of the femur fits, forming a ball-and-socket joint.
closed fracture. Break in a bone without a concomitant opening in the skin.
fracture. Break in bone or cartilage.
open fracture. Exposed break in a bone, always considered compound due to its high risk of infection from the open wound leading to the fracture.
pelvis. Distal anterior portion of the trunk that lies between the hipbones, sacrum, and coccyx bones.

Surgical to Anesthesia Code Crosswalk
27226, 27227, 27228

ICD-9-CM Diagnostic Codes
733.19 Pathologic fracture of other specified site
805.6 Closed fracture of sacrum and coccyx without mention of spinal cord injury
806.61 Closed fracture of sacrum and coccyx with complete cauda equina lesion
806.62 Closed fracture of sacrum and coccyx with other cauda equina injury
806.79 Open fracture of sacrum and coccyx with other spinal cord injury
808.0 Closed fracture of acetabulum
808.1 Open fracture of acetabulum
808.2 Closed fracture of pubis
808.3 Open fracture of pubis
808.41 Closed fracture of ilium
808.43 Multiple closed pelvic fractures with disruption of pelvic circle
808.51 Open fracture of ilium
808.53 Multiple open pelvic fractures with disruption of pelvic circle
839.42 Closed dislocation, sacrum
839.52 Open dislocation, sacrum
839.69 Closed dislocation, other location
839.79 Open dislocation, other location

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for obturator neurectomy; extrapelvic
intrapelvic

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
neurectomy. Excision of all or a portion of a nerve.
neuritis. Inflammation of a nerve or group of nerves, often manifested by loss of function and reflexes, pain, and numbness or tingling.
phantom limb syndrome. Itching, dull ache, or sharp, shooting pains mimicking the nerves of amputated limb.

Surgical to Anesthesia Code Crosswalk
64761, 64763, 64766

ICD-9-CM Diagnostic Codes
171.3 Malignant neoplasm of connective and other soft tissue of lower limb, including hip
198.82 Secondary malignant neoplasm of genital organs
198.89 Secondary malignant neoplasm of other specified sites
215.3 Other benign neoplasm of connective and other soft tissue of lower limb, including hip
225.8 Benign neoplasm of other specified sites of nervous system
236.3 Neoplasm of uncertain behavior of other and unspecified female genital organs
237.71 Neurofibromatosis, Type 1 (von Recklinghausen’s disease)
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
351.1 Geniculate ganglionitis
353.6 Phantom limb (syndrome)
355.71 Causalgia of lower limb
355.9 Mononeuritis of unspecified site
623.2 Stricture or atresia of vagina — (Use additional E code to identify any external cause)
625.0 Dyspareunia
669.81 Other complication of labor and delivery, delivered, with or without mention of antepartum condition
729.2 Unspecified neuralgia, neuritis, and radiculitis
907.5 Late effect of injury to peripheral nerve of pelvic girdle and lower limb
956.5 Injury to other specified nerve(s) of pelvic girdle and lower limb

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3; 100-4,12,140.3; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for all closed procedures involving hip joint

Coding Tips
This code is used to report anesthesia during all closed procedures involving the hip joint. For anesthesia during arthroscopic procedures, see code 01202; during open procedures, see codes 01210-01215. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
acetabulum. Cup-shaped socket in the hipbone into which the head of the femur fits, forming a ball-and-socket joint.
closed fracture. Break in a bone without a concomitant opening in the skin.
congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
contracture. Shortening of muscle or connective tissue.
dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.
ilium. Part of the iliac bone. Superior part of the hip bone that expands.
joint. Area of contact, or juncture, between two or more bones, often articulating with each other.
osteoarthritis. Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.
rheumatoid arthritis. Autoimmune disease causing pain, stiffness, inflammation, and possibly joint destruction.

Surgical to Anesthesia Code Crosswalk
0299T, 20694, 27095, 27175, 27220, 27257, 27266, 27275, 29320

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.2; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for arthroscopic procedures of hip joint

**Coding Tips**
This code is used to report anesthesia during procedures performed arthroscopically on the hip joint. For procedures performed via a closed approach, see code 01200. For procedures performed through an open approach, see codes 01210-01215.

**Terms To Know**

- **arthroscopy.** Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).
- **joint.** Area of contact, or juncture, between two or more bones, often articulating with each other.

**Surgical to Anesthesia Code Crosswalk**

171.3 Malignant neoplasm of connective and other soft tissue of lower limb, including hip
198.89 Secondary malignant neoplasm of other specified sites
213.7 Benign neoplasm of pelvic bones, sacrum, and coccyx
215.3 Other benign neoplasm of connective and other soft tissue of lower limb, including hip
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
275.40 Unspecified disorder of calcium metabolism — (Use additional code to identify any associated intellectual disabilities)
275.42 Hypercalcemia — (Use additional code to identify any associated intellectual disabilities)
275.49 Other disorders of calcium metabolism — (Use additional code to identify any associated intellectual disabilities)
711.05 Pyogenic arthritis, pelvic region and thigh — (Use additional code to identify infectious organism: 041.0-041.8)
714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)
715.15 Primary localized osteoarthrosis, pelvic region and thigh
716.95 Unspecified arthropathy, pelvic region and thigh
718.05 Articular cartilage disorder, pelvic region and thigh
718.15 Loose body in pelvic joint
718.35 Recurrent dislocation of pelvic region and thigh joint
718.75 Developmental dislocation of joint, pelvic region and thigh
719.25 Villonodular synovitis, pelvic region and thigh
719.45 Pain in joint, pelvic region and thigh
719.95 Unspecified disorder of joint of pelvic region and thigh
726.5 Enthesopathy of hip region
727.00 Unspecified synovitis and tenosynovitis
732.1 Juvenile osteochondrosis of hip and pelvis
732.9 Unspecified osteochondropathy
733.90 Disorder of bone and cartilage, unspecified
733.92 Chondromalacia
733.99 Other disorders of bone and cartilage
820.01 Closed fracture of epiphysis (separation) (upper) of neck of femur
835.00 Closed dislocation of hip, unspecified site
835.03 Other closed anterior dislocation of hip
843.8 Sprain and strain of other specified sites of hip and thigh
843.9 Sprain and strain of unspecified site of hip and thigh
905.6 Late effect of dislocation
908.9 Late effect of unspecified injury
959.6 Injury, other and unspecified, hip and thigh

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**

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Anesthesia for open procedures involving hip joint; not otherwise specified

01210 hip disarticulation
01212 total hip arthroplasty
01214 revision of total hip arthroplasty

Coding Tips
Correct code assignment for anesthesia performed during open procedures on the hip is dependent upon the type of surgical procedure being performed. For anesthesia provided during closed surgical procedures, see code 01200. For anesthesia provided during arthroscopic procedures, see code 01202. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
Arthroplasty. Surgical reconstruction of a joint to improve function and reduce pain. Arthroplasty may involve partial or total joint replacement. Coding depends upon site and method.
Disarticulation. Removal of a limb through a joint.

Surgical to Anesthesia Code Crosswalk
11044, 20150, 20650, 20670, 20680, 20690, 20692, 20694, 20696, 20697, 26990, 27027, 27030, 27033, 27035, 27036, 27045, 27052, 27054, 27065, 27066, 27067, 27070, 27071, 27087, 27090, 27091, 27120, 27122, 27125, 27130, 27132, 27134, 27137, 27138, 27140, 27146, 27147, 27151, 27156, 27176, 27177, 27178, 27185, 27253, 27254, 27258, 27259, 27284, 27286, 27295, S2115, S2325

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.3; 100-4,12,140.4.4

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Coding and Payment Guide for Anesthesia Services

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Also not with 01210: 99315, 99318, 99341-99343, 99347-99349
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Also not with 01214: 01215, 99315, 99318, 99341-99343, 99347-99349
Also not with 01215: 99315-99318, 99341-99343, 99347-99349
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01220  

**Coding Tips**  
This code represents anesthesia performed during procedures on the upper two thirds of the femur via a closed approach. For procedures performed through an open approach, see codes 01230-01234. For procedures performed on the lower one third of the femur, see code 01340 or 01360. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**  
- **closed fracture.** Break in a bone without a concomitant opening in the skin.  
- **condyle.** Rounded end of a bone that forms an articulation.  
- **dislocation.** Displacement of a bone in relation to its neighboring tissue, especially a joint.  
- **epiphysis.** End of a long bone.

**Surgical to Anesthesia Code Crosswalk**  
20220, 20225, 20615, 20670, 20694, 20982, 27230, 27232, 27235, 27238, 27240, 27267, 27268, 27500, 27502

**ICD-9-CM Diagnostic Codes**  
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**  
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified**

**01230**  
Anesthesia for open procedures involving upper 2/3 of femur; not otherwise specified

**01232**  
amputation

**01234**  
radical resection

**Coding Tips**

Correct code selection is dependent upon the surgical procedure performed. For anesthesia provided during closed procedures, see code 01220. For anesthesia provided during procedures involving the lower one half of the femur, see codes 01340 and 01360. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- **amputation.** Removal of all or part of a limb or digit through the shaft or body of a bone. Amputation can be the diagnosis in cases of accidental injury or the procedure in cases of surgery.
- **resection.** Surgical removal of a part or all of an organ or body part.

**Surgical to Anesthesia Code Crosswalk**

11012, 11044, 15951, 15953, 15958, 20150, 20225, 20240, 20245, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 27078, 27140, 27161, 27165, 27170, 27179, 27181, 27187, 27236, 27244, 27245, 27248, 27269, 27303, 27355, 27356, 27357, 27360, 27365, 27448, 27450, 27454, 27470, 27472, 27495, 27506, 27507, 27590, 27591, 27592, 27596

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **bursa**: Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.
- **fascia**: Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
- **mononeuropathy**: Disease concentrated on one nerve.
- **neurectomy**: Excision of all or a portion of a nerve.
- **neuropathy**: Abnormality, disease, or malfunction of the nerves.
- **polyneuropathy**: Disease process of severe inflammation of multiple nerves.
- **tendon**: Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
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CCI Version 20.0

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<tr>
<th>Procedure Code</th>
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<tr>
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<td>Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of upper leg</td>
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</table>

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Anesthesia for all procedures involving veins of upper leg, including exploration

**Coding Tips**
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**

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<tr>
<th>Code</th>
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<tr>
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**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>440.21</td>
<td>Atherosclerosis of native arteries of the extremities with intermittent claudication</td>
</tr>
<tr>
<td>440.22</td>
<td>Atherosclerosis of native arteries of the extremities with rest pain</td>
</tr>
<tr>
<td>440.24</td>
<td>Atherosclerosis of native arteries of the extremities with gangrene — (Use additional code for any associated ulceration: 707.10-707.19, 707.8, 707.9)</td>
</tr>
<tr>
<td>440.31</td>
<td>Atherosclerosis of autologous vein bypass graft of extremities</td>
</tr>
<tr>
<td>440.32</td>
<td>Atherosclerosis of nonautologous biological bypass graft of extremities</td>
</tr>
<tr>
<td>451.0</td>
<td>Phlebitis and thrombophlebitis of superficial vessels of lower extremities — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>451.11</td>
<td>Phlebitis and thrombophlebitis of femoral vein (deep) (superficial) — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>451.81</td>
<td>Phlebitis and thrombophlebitis of iliac vein — (Use additional E code to identify drug, if drug-induced)</td>
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<tr>
<td>453.41</td>
<td>Acute venous embolism and thrombosis of superficial vessels of proximal lower extremity</td>
</tr>
<tr>
<td>453.42</td>
<td>Acute venous embolism and thrombosis of deep vessels of proximal lower extremity</td>
</tr>
<tr>
<td>454.0</td>
<td>Varicose veins of lower extremities with ulcer</td>
</tr>
<tr>
<td>454.1</td>
<td>Varicose veins of lower extremities with inflammation</td>
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<tr>
<td>454.2</td>
<td>Varicose veins of lower extremities with ulcer and inflammation</td>
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<tr>
<td>459.10</td>
<td>Postphlebitic syndrome without complications</td>
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<tr>
<td>459.11</td>
<td>Postphlebitic syndrome with ulcer</td>
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<tr>
<td>459.12</td>
<td>Postphlebitic syndrome with inflammation</td>
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<tr>
<td>459.13</td>
<td>Postphlebitic syndrome with ulcer and inflammation</td>
</tr>
<tr>
<td>459.19</td>
<td>Postphlebitic syndrome with other complication</td>
</tr>
<tr>
<td>459.2</td>
<td>Compression of vein</td>
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<tr>
<td>639.6</td>
<td>Embolism following abortion or ectopic and molar pregnancies</td>
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<tr>
<td>707.11</td>
<td>Ulcer of thigh — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)</td>
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<tr>
<td>747.41</td>
<td>Total congenital anomalous pulmonary venous connection</td>
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<tr>
<td>747.64</td>
<td>Congenital lower limb vessel anomaly</td>
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<tr>
<td>901.2</td>
<td>Superior vena cava injury</td>
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<td>902.54</td>
<td>Iliac vein injury</td>
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<td>904.2</td>
<td>Femoral vein injury</td>
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<td>904.3</td>
<td>Saphenous vein injury</td>
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<tr>
<td>904.4</td>
<td>Popliteal vein injury</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01270-01274
01270  Anesthesia for procedures involving arteries of upper leg, including bypass graft; not otherwise specified
01272  femoral artery ligation
01274  femoral artery embolectomy

Coding Tips
Correct code assignment is dependent upon the type of surgical procedure performed. For anesthesia during procedures of the arteries of the knee and popliteal area, see codes 01440-01442. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bypass graft. Surgically created alternative blood vessel used to reroute blood flow around an area of obstruction or disease.
embolectomy. Surgical excision of a blood clot or other foreign material that broke away from its original source and traveled in the bloodstream, becoming lodged in a blood vessel and blocking circulation.

Surgical to Anesthesia Code Crosswalk
0238T, 20962, 20969, 33970, 33971, 34201, 34812, 35141, 35142, 35226, 35256, 35302, 35371, 35372, 35381, 35456, 35483, 35485, 35493, 35556, 35558, 35583, 35585, 35587, 35656, 35661, 35666, 35721, 35761, 35860, 35875, 35876, 35879, 35881, 35883, 35884, 35903, 36140, 36245, 36246, 36247, 37224, 37225, 37226, 37227, 37607, 37618, 64577

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3,2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area

Coding Tips
For anesthesia during surgical procedures of the upper leg, see code 01250; lower leg, see code 01470. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
Baker’s cyst. Sac filled with clear synovial fluid in adults, usually secondary to disease inside the joint, located on the back of the knee in the popliteal fossa area. In children, the cyst usually represents a ganglion of one of the tendons in the knee. This condition is reported with ICD-9-CM code 727.51 or ICD-10-CM code M71.2 [0, 1, 2] or M66.0 ruptured. Removal of a Baker’s cyst is reported with CPT code 27345.

bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.

connective tissue. Body tissue made from fibroblasts, collagen, and elastic fibers that connects, supports, and holds together other tissues and cells and includes cartilage, collagenous, fibrous, elastic, and osseous tissue.

contracture. Shortening of muscle or connective tissue.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

lipoma. Benign tumor containing fat cells and the most common of soft tissue lesions, which are usually painless and asymptomatic, with the exception of an angiolipoma.

mononeuritis. Inflammation of one nerve.

neuropathy. Abnormality, disease, or malfunction of the nerves.

dysesthesia. Disease process of severe inflammation of multiple nerves.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

Surgical to Anesthesia Code Crosswalk
11011, 11043, 15738, 15758, 20005, 20200, 20205, 20206, 20205, 20525, 20555, 20950, 27301, 27320, 27324, 27326, 27328, 27329, 27339, 27340, 27345, 27364, 27372, 27380, 27381, 27385, 27386, 27390, 27391, 27392, 27393, 27394, 27395, 27396, 27397, 27400, 27420, 27422, 27425, 27427, 27430, 27435, 27496, 27497, 27498, 27499, 27603, 64575, 64577, 64580, 64585, 64708, 64722, 64784, 64788, 64790, 64792, 6483, 64856, 64857, 64892, 64893, 648988, 64905, 64907, 64910, 64911

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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<th>Base Unit</th>
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</table>
Coding and Payment Guide for Anesthesia Services

ICD-9-CM Diagnostic Codes

- 170.7 Malignant neoplasm of long bones of lower limb
- 198.5 Secondary malignant neoplasm of bone and bone marrow
- 203.11 Plasma cell leukemia in remission
- 213.7 Benign neoplasm of long bones of lower limb
- 273.1 Monoclonal paraproteinemia — (Use additional code to identify any associated intellectual disabilities)
- 730.16 Chronic osteomyelitis, lower leg — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
- 730.19 Chronic osteomyelitis, multiple sites — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
- 730.26 Unspecified osteomyelitis, lower leg — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
- 732.2 Nontraumatic slipped upper femoral epiphysis
- 732.6 Other juvenile osteochondrosis
- 733.01 Senile osteoporosis — (Use additional code to identify major osseous defect, if applicable: 731.3) (Use additional code to identify personal history of pathologic (healed) fracture: V13.51)
- 733.15 Pathologic fracture of other specified part of femur
- 733.20 Unspecified cyst of bone (localized)
- 733.21 Solitary bone cyst
- 733.22 Aneurysmal bone cyst
- 733.43 Aseptic necrosis of medial femoral condyle — (Use additional code to identify major osseous defect, if applicable: 731.3)
- 733.95 Stress fracture of other bone — (Use additional code(s) to identify the cause of the stress fracture)

Surgical to Anesthesia Code Crosswalk

20220, 20225, 20615, 20665, 20670, 20694, 20982, 27501, 27503, 27508, 27509, 27510, 27516, 27517

ICD-9-CM Diagnostic Codes

- 756.51 Osteogenesis imperfecta
- 821.01 Closed fracture of shaft of femur
- 821.10 Open fracture of unspecified part of femur
- 821.11 Open fracture of shaft of femur
- 821.20 Closed fracture of unspecified part of lower end of femur
- 821.21 Closed fracture of femoral condyle
- 821.22 Closed fracture of lower epiphysis of femur
- 821.23 Closed supracondylar fracture of femur
- 821.30 Open fracture of unspecified part of lower end of femur
- 821.31 Open fracture of femoral condyle
- 821.32 Open fracture of lower epiphysis of femur
- 821.33 Open supracondylar fracture of femur
- 827.1 Other, multiple and ill-defined closed fractures of lower limb
- 828.0 Multiple closed fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
- 828.1 Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, open

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

- 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

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<th>Procedure Codes</th>
<th>Coding and Payment Guide for Anesthesia Services</th>
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Anesthesia for all open procedures on lower 1/3 of femur

Coding Tips
This code is used to report anesthesia services during open procedures of the lower one third of the femur. When the surgical service is closed, report code 01340. To report anesthesia during open or surgical arthroscopic procedures of the knee, see code 01400; for diagnostic arthroscopic procedures, see code 01382. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
ankylosis. Abnormal union or fusion of bones in a joint, which is normally moveable.
chondromalacia. Condition in which the articular cartilage softens, seen in various body sites but most often in the patella, and may be congenital or acquired.
granuloma. Abnormal, dense collections or cells forming a mass or nodule of chronically inflamed tissue with granulations that is usually associated with an infective process.
osteoarthrosis. Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.
osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.
pressure ulcers. Progressively erosive skin lesion produced by inflamed necrotic tissue as it sloughs off, caused by continual pressure impeding blood circulation, especially over bony areas, when a patient lies still for too long without changing position.
rhabdomyolysis. Condition resulting in the breakdown of skeletal muscle tissue.
tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

Surgical to Anesthesia Code Crosswalk
11012, 11044, 20150, 20240, 20245, 20650, 20670, 20680, 20690, 20692, 20693, 20694, 20697, 27303, 27355, 27356, 27357, 27360, 27365, 27448, 27450, 27465, 27466, 27468, 27470, 27472, 27475, 27479, 27485, 27495, 27506, 27511, 27513, 27514, 27519

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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</table>

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**01380**

01380  Anesthesia for all closed procedures on knee joint

**Coding Tips**

This code reports anesthesia performed during closed procedures. When an open procedure or surgical arthroscopy is performed, report code 01400. When diagnostic arthroscopy is performed, report code 01382. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**

20694, 20982, 27370, 27552, 27570, 29530

**ICD-9-CM Diagnostic Codes**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
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<td>357.1</td>
<td>Polynuropathy in collagen vascular disease — (Code first underlying disease: 446.0, 710.0, 714.0)</td>
</tr>
<tr>
<td>359.6</td>
<td>Symptomatic inflammatory myopathy in diseases classified elsewhere — (Code first underlying disease: 135, 140.0-208.9, 277.30-277.39, 446.0, 710.0, 710.1, 710.2, 714.0)</td>
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<tr>
<td>446.0</td>
<td>Polyarteritis nodosa</td>
</tr>
<tr>
<td>710.0</td>
<td>Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)</td>
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<tr>
<td>710.1</td>
<td>Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)</td>
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<td>710.2</td>
<td>Sicca syndrome</td>
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<tr>
<td>714.0</td>
<td>Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)</td>
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<tr>
<td>715.16</td>
<td>Primary localized osteoarthrosis, lower leg</td>
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<tr>
<td>715.96</td>
<td>Osteoarthrosis, unspecified whether generalized or localized, lower leg</td>
</tr>
<tr>
<td>716.96</td>
<td>Unspecified arthropathy, lower leg</td>
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<tr>
<td>717.1</td>
<td>Derangement of anterior horn of medial meniscus</td>
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<tr>
<td>717.42</td>
<td>Derangement of anterior horn of lateral meniscus</td>
</tr>
<tr>
<td>717.6</td>
<td>Loose body in knee</td>
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<tr>
<td>717.7</td>
<td>Chondromalacia of patella</td>
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<tr>
<td>717.83</td>
<td>Old disruption of anterior cruciate ligament</td>
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<tr>
<td>717.84</td>
<td>Old disruption of posterior cruciate ligament</td>
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<td>717.85</td>
<td>Old disruption of other ligament of knee</td>
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<td>718.26</td>
<td>Pathological dislocation of lower leg joint</td>
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<td>718.36</td>
<td>Recurrent dislocation of lower leg joint</td>
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<td>718.46</td>
<td>Contracture of lower leg joint</td>
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<td>718.56</td>
<td>Ankylosis of lower leg joint</td>
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<td>718.76</td>
<td>Developmental dislocation of joint, lower leg</td>
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<td>Effusion of lower leg joint</td>
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<td>Knee joint replacement by other means</td>
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</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4, 4, 250.3.2; 100-4, 12, 140.1; 100-4, 12, 140.3; 100-4, 12, 140.3.3; 100-4, 12, 140.3.4; 100-4, 12, 140.4.1; 100-4, 12, 140.4.2; 100-4, 12, 140.4.3; 100-4, 12, 140.4.4

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Base Unit</th>
<th>Work Value</th>
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01382

01382  Anesthesia for diagnostic arthroscopic procedures of knee joint

Coding Tips
For surgical arthroscopy procedures, see code 01400. When diagnostic and surgical arthroscopy are performed at the same session, the anesthesia for the diagnostic arthroscopy is included in the surgical arthroscopy code.

Surgical to Anesthesia Code Crosswalk
0012T, 0013T, 29870

ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>171.3</td>
<td>Malignant neoplasm of connective and other soft tissue of lower limb, including hip</td>
</tr>
<tr>
<td>215.3</td>
<td>Other benign neoplasm of connective and other soft tissue of lower limb, including hip</td>
</tr>
<tr>
<td>238.1</td>
<td>Neoplasm of uncertain behavior of connective and other soft tissue</td>
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<tr>
<td>239.2</td>
<td>Neoplasms of unspecified nature of bone, soft tissue, and skin</td>
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<tr>
<td>711.56</td>
<td>Arthropathy associated with other viral diseases, lower leg — (Code first underlying disease: 045-049, 050-079, 480, 487)</td>
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<tr>
<td>712.16</td>
<td>Chondrocalcinosis due to dicalcium phosphate crystals, lower leg — (Code first underlying disease: 275.4)</td>
</tr>
<tr>
<td>712.26</td>
<td>Chondrocalcinosis due to pyrophosphate crystals, lower leg — (Code first underlying disease: 275.4)</td>
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<tr>
<td>713.1</td>
<td>Arthropathy associated with gastrointestinal conditions other than infections — (Code first underlying disease: 555.0-555.9, 556)</td>
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<tr>
<td>713.2</td>
<td>Arthropathy associated with hematological disorders — (Code first underlying disease: 202.3, 203.0, 204.0-208.9, 282.4-282.7, 286.0-286.2)</td>
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<tr>
<td>713.3</td>
<td>Arthropathy associated with dermatological disorders — (Code first underlying disease: 695.10-695.19, 695.2)</td>
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<td>Primary localized osteoarthrosis, lower leg</td>
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<td>715.96</td>
<td>Osteoarthrosis, unspecified whether generalized or localized, lower leg</td>
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<tr>
<td>716.16</td>
<td>Traumatic arthropathy, lower leg</td>
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<tr>
<td>716.46</td>
<td>Transient arthropathy, lower leg</td>
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<tr>
<td>717.0</td>
<td>Old bucket handle tear of medial meniscus</td>
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<td>717.1</td>
<td>Derangement of anterior horn of medial meniscus</td>
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<tr>
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<tr>
<td>717.41</td>
<td>Bucket handle tear of lateral meniscus</td>
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<td>717.43</td>
<td>Derangement of posterior horn of lateral meniscus</td>
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<td>Derangement of meniscus, not elsewhere classified</td>
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<td>717.7</td>
<td>Chondromalacia of patella</td>
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<tr>
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<td>Old disruption of lateral collateral ligament</td>
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<td>717.84</td>
<td>Old disruption of posterior cruciate ligament</td>
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<td>717.85</td>
<td>Old disruption of other ligament of knee</td>
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<td>718.36</td>
<td>Recurrent dislocation of lower leg joint</td>
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<td>718.46</td>
<td>Contracture of lower leg joint</td>
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<td>718.76</td>
<td>Developmental dislocation of joint, lower leg</td>
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<td>719.06</td>
<td>Effusion of lower leg joint</td>
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<td>719.16</td>
<td>Hemarthrosis, lower leg</td>
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<td>719.26</td>
<td>Villonodular synovitis, lower leg</td>
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<td>727.51</td>
<td>Synovial cyst of popliteal space</td>
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<tr>
<td>733.90</td>
<td>Disorder of bone and cartilage, unspecified</td>
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<td>733.92</td>
<td>Chondromalacia</td>
</tr>
<tr>
<td>755.64</td>
<td>Congenital deformity of knee (joint)</td>
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<tr>
<td>836.0</td>
<td>Tear of medial cartilage or meniscus of knee, current</td>
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<tr>
<td>836.1</td>
<td>Tear of lateral cartilage or meniscus of knee, current</td>
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<tr>
<td>836.3</td>
<td>Closed dislocation of patella</td>
</tr>
<tr>
<td>836.4</td>
<td>Open dislocation of patella</td>
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<tr>
<td>Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.</td>
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IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<tr>
<th>Base Unit</th>
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01390-01392

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

Coding Tips

For anesthesia during closed procedures, see code 01390. For anesthesia during procedures performed on the lower leg through a closed approach, see code 01392. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

anterior cruciate ligament. Ligament composed of two parts: anteromedial and posterolateral bundle. It helps hold the tibia and femur together deep within the knee joint. When this tears or ruptures, it creates instability of the knee. Repair can be done either open or arthroscopically.

arthropathy. Disease of the joints.
cellulitis. Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.

chondromalacia. Condition in which the articular cartilage softens, seen in various body sites but most often in the patella, and may be congenital or acquired.
closed dislocation. Simple displacement of a body part without an open wound.
closed fracture. Break in a bone without a concomitant opening in the skin.

fracture types. There are three basic degrees of fracture: type I: a small crack in the bone without displacement; type II: a fracture in which the bone is slightly displaced; type III: a fracture in which there are more than three broken pieces of bone that cannot fit together.
granuloma. Abnormal, dense collections or cells forming a mass or nodule of chronically inflamed tissue with granulations that is usually associated with an infective process.

osteoarthritis. Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.

osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

pressure ulcers. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off, caused by continual pressure impeding blood circulation, especially over bony areas, when a patient lies still for too long without changing position.

prosthesis. Man-made substitute for a missing body part.

Surgical to Anesthesia Code Crosswalk

11012, 11044, 20220, 20240, 20615, 20650, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 27350, 27360, 27418, 27420, 27422, 27437, 27440, 27441, 27455, 27457, 27477, 27485, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27562, 27566, 27742

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,12,140.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<tr>
<th>Procedure Codes</th>
<th>Coding and Payment Guide for Anesthesia Services</th>
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01400

01400  Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified

Coding Tips
For diagnostic arthroscopy, see code 01382. When diagnostic arthroscopy precedes the surgical arthroscopy at the same session, only the surgical arthroscopy should be coded. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
arthropathy. Disease of the joints.
arthroscopy. Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).
bursitis. Inflammation of a bursa.
chondromalacia. Condition in which the articular cartilage softens, seen in various body sites but most often in the patella, and may be congenital or acquired.
contracture. Shortening of muscle or connective tissue.
dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.
hemarthrosis. Occurrence of blood within a joint space.
joint. Area of contact, or juncture, between two or more bones, often articulating with each other.
synovitis. Inflammation of the synovial membrane that lines a synovial joint, resulting in pain and swelling.

Surgical to Anesthesia Code Crosswalk
0014T, 11012, 11044, 20150, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 27303, 27330, 27331, 27332, 27333, 27334, 27345, 27347, 27348, 27350, 27405, 27407, 27409, 27412, 27415, 27416, 27418, 27428, 27429, 27435, 27442, 27443, 27445, 27446, 27516, 27557, 27558, 27580, 29850, 29851, 29855, 29856, 29866, 29867, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, G0428, S2112

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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</table>
**Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty**

**Coding Tips**
Appropriate code selection is dependent upon the procedure performed. Report code 01402 for arthroplasty (surgical codes 27447 or 27486-27488) or code 01404 for disarticulation of knee joint (surgical code 27598). See the Surgical to Anesthesia Crosswalk for specific surgical codes that are associated with this anesthesia service. These procedures may be performed by an open or arthroscopic approach. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**
- **ankylosis.** Abnormal union or fusion of bones in a joint, which is normally moveable.
- **arthropathy.** Disease of the joints.
- **arthroplasty.** Surgical reconstruction of a joint to improve function and reduce pain; may involve partial or total joint replacement.
- **aseptic necrosis.** Death of bone tissue resulting from a disruption in the vascular supply, caused by a noninfectious disease process, such as a fracture or the administration of immunosuppressive drugs.
- **disarticulation.** Removal of a limb through a joint.
- **ostearthrosis.** Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.
- **osteomyelitis.** Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.
- **prosthesis.** Man-made substitute for a missing body part.

**Surgical to Anesthesia Code Crosswalk**
27447, 27486, 27487, 27488, 27598

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Coding and Payment Guide for Anesthesia Services</th>
<th>CCI Version 20.0</th>
</tr>
</thead>
</table>

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for all cast applications, removal, or repair involving knee joint

**Coding Tips**
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**
29345, 29355, 29358, 29365, 29435, 29440, 29445, 29505, 29705, 29730, 29740

**ICD-9-CM Diagnostic Codes**
454.0 Varicose veins of lower extremities with ulcer
454.1 Varicose veins of lower extremities with inflammation
454.2 Varicose veins of lower extremities with ulcer and inflammation
459.10 Postphlebitic syndrome without complications
459.11 Postphlebitic syndrome with ulcer
459.12 Postphlebitic syndrome with inflammation
459.13 Postphlebitic syndrome with ulcer and inflammation
459.30 Chronic venous hypertension without complications
459.31 Chronic venous hypertension with ulcer
459.32 Chronic venous hypertension with inflammation
459.33 Chronic venous hypertension with ulcer and inflammation
459.39 Chronic venous hypertension with other complication
715.16 Primary localized osteoarthrosis, lower leg
717.82 Old disruption of medial collateral ligament
718.36 Recurrent dislocation of lower leg joint
718.76 Developmental dislocation of joint, lower leg
726.64 Patellar tendinitis
727.65 Nontraumatic rupture of quadriceps tendon
727.66 Nontraumatic rupture of patellar tendon
732.4 Juvenile osteochondrosis of lower extremity, excluding foot
733.81 Malunion of fracture
733.82 Nonunion of fracture
733.93 Stress fracture of tibia or fibula — (Use additional external cause code(s) to identify the cause of the stress fracture)
754.42 Congenital bowing of femur
821.21 Closed fracture of femoral condyle
821.22 Closed fracture of lower epiphysis of femur
821.23 Closed supracondylar fracture of femur

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Coding and Payment Guide for Anesthesia Services</th>
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<tbody>
<tr>
<td>01420</td>
<td>Anesthesia for all cast applications, removal, or repair involving knee joint</td>
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<tr>
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<td>Anesthesia for all cast applications, removal, or repair involving knee joint</td>
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</table>

**CCI Version 20.0**

**Note:** These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
## Coding and Payment Guide for Anesthesia Services

### Procedure Codes

| 01430-01432 | Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified |
| 01430 | Arteriovenous fistula |

#### Coding Tips

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

### Surgical to Anesthesia Code Crosswalk

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<td>35190</td>
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### ICD-9-CM Diagnostic Codes

<table>
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<tr>
<th>Code</th>
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<tr>
<td>440.30</td>
<td>Atherosclerosis of unspecified bypass graft of extremities</td>
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<td>440.31</td>
<td>Atherosclerosis of autologous vein bypass graft of extremities</td>
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<td>440.32</td>
<td>Atherosclerosis of nonautologous biological bypass graft of extremities</td>
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<tr>
<td>443.89</td>
<td>Other peripheral vascular disease</td>
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<tr>
<td>453.40</td>
<td>Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity</td>
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<td>453.41</td>
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<td>Acute venous embolism and thrombosis of deep vessels of distal lower extremity</td>
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<td>Varicose veins of lower extremities with ulcer and inflammation</td>
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<td>Asymptomatic varicose veins</td>
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<td>Postphlebitic syndrome with ulcer and inflammation</td>
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<td>459.19</td>
<td>Postphlebitic syndrome with other complication</td>
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<td>459.2</td>
<td>Compression of vein</td>
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<td>Ulcer of other part of lower limb — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)</td>
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</tbody>
</table>

#### Note

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

### CCI Version 20.0

<table>
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01440-01444

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

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.
endarterectomy. Removal of the thickened, endothelial lining of a diseased or damaged artery.
graft. Tissue implant from another part of the body or another person.
occlusion. Constriction, closure, or blockage of a passage.
thrombo-. Relating to blood clots.

Surgical to Anesthesia Code Crosswalk
35151, 35152, 35226, 35286, 35303, 35304, 35305, 35381, 353571, 35671, 35741, 35860, 35875, 35876, 35879, 35881, 36140, 36245, 36246, 36247, 37224, 37225, 37226, 37227, 37607, 37618

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4, 4,250.3.2; 100-4,12, 140.1; 100-4,12, 140.3; 100-4,12, 140.3.3; 100-4,12, 140.3.4; 100-4,12, 140.4.1; 100-4,12, 140.4.2; 100-4,12, 140.4.3; 100-4,12, 140.4.4

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CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for all closed procedures on lower leg, ankle, and foot

Coding Tips
This code represents anesthesia services performed during closed procedures on the leg, ankle, and foot. If the surgeon employs an arthroscopic approach, see code 01464. For open procedures, see codes 01480-01486. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- closed dislocation. Simple displacement of a body part without an open wound.
- closed fracture. Break in a bone without a concomitant opening in the skin.
- effusion. Escape of fluid from within a body cavity.
- malleolus. Rounded protuberances on each side of the ankle. The lateral malleolus is the fibula and the medial is the tibia.
- pathologic fracture. Break in bone due to a disease process that weakens the bone structure, such as osteoporosis, osteomalacia, or neoplasia, and not traumatic injury.
- stress fracture. Fracture of the bone caused by repetitive overuse. Frequently occurring in the setting of heavy physical labor, sports, or strenuous exercise, these fractures are particularly common in the metatarsal bones of the foot. Treatment consists of disuse, rest, and occasionally casting or splinting to avoid reinjury during the healing process. Report stress fractures with a code from ICD-9-CM subcategory 733.9, and personal history with V13.52.

Surgical to Anesthesia Code Crosswalk
0020T, 0299T, 20220, 20615, 20670, 20694, 20982, 27648, 27745, 27750, 27752, 27756, 27760, 27762, 27767, 27768, 27780, 27781, 27786, 27788, 27808, 27810, 27816, 27818, 27824, 27825, 27831, 27842, 27860, 28400, 28405, 28406, 28430, 28435, 28436, 28450, 28455, 28456, 28470, 28475, 28476, 28490, 28495, 28496, 28510, 28515, 28530, 28545, 28546, 28575, 28576, 28605, 28606, 28635, 28636, 28665, 28666, 28890, 29540, 29550, 29580, 29581, 29582, 29390

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
Anesthesia for arthroscopic procedures of ankle and/or foot

Coding Tips
This code includes anesthesia performed at the time of both diagnostic and surgical arthroscopies (surgical codes 29891-29895, 29897-29899, and 29904-29907). The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
arthrodesis. Surgical fixation or fusion of a joint to reduce pain and improve stability, performed openly or arthroscopically.
arthroscopy. Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).
enthesopathy. Disorders that occur at points where muscle tendons and ligaments attach to bones or joint capsules. Enthesopathy is reported with a code from ICD-9-CM category 726, dependent upon the location, or to 720.1 when affecting the spine.
osteochondritis dissecans. Inflammation of the bone and cartilage that results in splinters or pieces of cartilage breaking off in the joint.
synovitis. Inflammation of the synovial membrane that lines a synovial joint, resulting in pain and swelling.

Surgical to Anesthesia Code Crosswalk
29891, 29892, 29893, 29894, 29895, 29897, 29898, 29899, 29904, 29905, 29906, 29907

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; not otherwise specified

- **01470**: repair of ruptured Achilles tendon, with or without graft
- **01472**: gastrocnemius recession (eg, Strayer procedure)

**Coding Tips**
Correct code selection is dependent upon the procedure being performed. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**
- **Achilles tendon**: Tendon attached to the back of the heel bone (calcaneus) that flexes the foot downward.
- **Fascia**: Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
- **Gastrocnemius**: Large muscle of the back of the leg that flexes the foot and knee; the outermost portion of the muscle group that is commonly referred to as the calf muscle.
- **Graft**: Tissue implant from another part of the body or another person.
- **Rupture**: Tearing or breaking open of tissue.

**Surgical to Anesthesia Code Crosswalk**
11011, 11043, 15738, 15758, 20005, 20200, 20205, 20206, 20520, 20525, 20555, 20924, 20950, 27600, 27601, 27602, 27603, 27604, 27606, 27614, 27615, 27616, 27630, 27634, 27650, 27652, 27654, 27656, 27658, 27659, 27664, 27665, 27675, 27680, 27681, 27685, 27686, 27687, 27690, 27691, 27695, 27696, 27698, 27892, 27893, 27894, 28001, 28002, 28003, 28008, 28010, 28011, 28030, 28035, 28041, 28045, 28046, 28047, 28055, 28060, 28062, 28070, 28072, 28080, 28086, 28088, 28090, 28092, 28192, 28193, 28200, 28202, 28208, 28210, 28220, 28222, 28225, 28226, 28230, 28232, 28234, 28236, 28240, 28250, 28260, 28261, 28262, 28264, 28270, 28272, 28280, 28313, 28340, 28820, 28825, 64575, 64577, 64580, 64585, 64588, 64670, 64704, 64706, 64722, 64726, 64776, 64782, 64784, 64788, 64790, 64792, 64795, 64820, 64831, 64843, 64840, 64856, 64857, 64890, 64891, 64892, 64893, 64895, 64896, 64897, 64898, 64905, 64907, 64910, 64911

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-4,230.3.2; 100-4,12,140.1; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**Procedure Codes**

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Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified

01480  radical resection (including below knee amputation)

01482  osteotomy or osteoplasty of tibia and/or fibula

01484  total ankle replacement

Coding Tips
Correct code assignment is dependent upon the type of procedure performed. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
amputation. Removal of all or part of a limb or digit through the shaft or body of a bone. Amputation can be the diagnosis in cases of accidental injury or the procedure in cases of surgery.

joint replacement. Insertion of new substitute material in place of damaged or diseased joint tissue to restore function and movement.

osteoplasty. Plastic surgery of a bone.

osteotomy. Surgical cutting of a bone.

radical resection. Removal of an entire tumor (e.g., malignant neoplasm) along with a large area of surrounding tissue, including adjacent lymph nodes that may have been infiltrated.

Surgical to Anesthesia Code Crosswalk
0335T, 11027, 11028, 11044, 20150, 20240, 20650, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 20975, 27607, 27610, 27612, 27620, 27625, 27626, 27635, 27637, 27638, 27640, 27641, 27645, 27664, 27667, 27700, 27702, 27703, 27704, 27705, 27707, 27709, 27712, 27715, 27720, 27722, 27724, 27725, 27726, 27727, 27730, 27732, 27734, 27740, 27745, 27758, 27759, 27766, 27769, 27784, 27792, 27814, 27822, 27823, 27826, 27827, 27828, 27829, 27832, 27846, 27848, 27870, 27871, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28005, 28020, 28022, 28024, 28030, 28052, 28054, 28100, 28102, 28104, 28106, 28107, 28108, 28110, 28111, 28112, 28113, 28114, 28116, 28118, 28119, 28120, 28122, 28124, 28126, 28130, 28140, 28150, 28153, 28160, 28171, 28173, 28175, 28285, 28286, 28288, 28289, 28290, 28292, 28293, 28294, 28296, 28297, 28298, 28299, 28300, 28302, 28303, 28305, 28306, 28307, 28308, 28309, 28310, 28312, 28313, 28315, 28320, 28322, 28341, 28344, 28345, 28360, 28415, 28420, 28445, 28464, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 28800, 28805, 28810, 28820, 28825, 52117

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

ICD-9-CM Diagnostic Codes

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IOM References
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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01490
01490  Anesthesia for lower leg cast application, removal, or repair

**Coding Tips**
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**
- **Achilles tendon**: Tendon attached to the back of the heel bone (calcaneus) that flexes the foot downward.
- **Ankylosis**: Abnormal union or fusion of bones in a joint, which is normally moveable.
- **Calcaneal spur**: Overgrowth of the calcaneus bone from calcium deposits and chronic avulsion of the plantar fascia from the heel bone. A bone spur forms at the attachment points of tendons in the mid and hind foot region on the lower surface of the calcaneus and causes pain and tenderness with walking.
- **Cast**: Rigid encasement or dressing molded to the body from a substance that hardens upon drying to hold a body part immobile during the healing period; a model or reproduction made from an impression or mold.
- **Closed fracture**: Break in a bone without a concomitant opening in the skin.
- **Contracture**: Shortening of muscle or connective tissue.
- **Open fracture**: Exposed break in a bone, always considered compound due to its high risk of infection from the open wound leading to the fracture.
- **Removal**: Process of moving out of or away from, or the fact of being removed.

**Surgical to Anesthesia Code Crosswalk**
29405, 29425, 29450, 29515, 29730, 29740, 29750

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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01500-01502

01500  Anesthesia for procedures on arteries of lower leg, including bypass graft; not otherwise specified
01502  embolectomy, direct or with catheter

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bypass graft. Surgically created alternative blood vessel used to reroute blood flow around an area of obstruction or disease.
embolectomy. Surgical excision of a blood clot or other foreign material that broke away from its original source and traveled in the blood stream, becoming lodged in a blood vessel and blocking circulation.
embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.
gangrene. Death of tissue, usually resulting from a loss of vascular supply, followed by a bacterial attack or onset of disease.
traumatic amputation. Removal of a part or limb from accidental injury.

Surgical to Anesthesia Code Crosswalk
20838, 20955, 20957, 20972, 34203, 35184, 35226, 35256, 35286, 35304, 35305, 35459, 35485, 35495, 35570, 35571, 35587, 35761, 35860, 35875, 35876, 35879, 35881, 36140, 36245, 36246, 36247, 37228, 37229, 37230, 37231, 37607, 37618

ICD-9-CM Diagnostic Codes
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IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01520-01522

01520  Anesthesia for procedures on veins of lower leg; not otherwise specified
01522  venous thrombectomy, direct or with catheter

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
35226, 35256, 35286, 35460, 35875, 35876, 36475, 36478, 37500, 37700, 37718, 37720, 37730, 37735, 37760, 37761, 37765, 37766, 37785

ICD-9-CM Diagnostic Codes
440.31  Atherosclerosis of autologous vein bypass graft of extremities
440.32  Atherosclerosis of nonautologous biological bypass graft of extremities
453.40  Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.42  Acute venous embolism and thrombosis of deep vessels of distal lower extremity
454.0  Varicose veins of lower extremities with ulcer
454.1  Varicose veins of lower extremities with inflammation
454.2  Varicose veins of lower extremities with ulcer and inflammation
454.8  Varicose veins of the lower extremities with other complications
454.9  Asymptomatic varicose veins
459.10  Postphlebitic syndrome without complications
459.11  Postphlebitic syndrome with ulcer
459.12  Postphlebitic syndrome with inflammation
459.13  Postphlebitic syndrome with ulcer and inflammation
459.19  Postphlebitic syndrome with other complication
459.2  Compression of vein
707.10  Ulcer of lower limb, unspecified — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.12  Ulcer of calf — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)
707.13  Ulcer of ankle — (Code, if applicable, any causal condition first: 249.80-249.81, 250.80-250.83, 440.23, 459.11, 459.13, 459.31, 459.33)

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

ICM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0
0178T-0179T, 0180T, 01996, 0213T, 0216T, 0228T, 0230T, 0282T-0283T, 0311T, 35226, 35256, 35460, 35875, 35876, 36475, 36478, 37500, 37700, 37718, 37720, 37730, 37735, 37760, 37761, 37765, 37766, 37785

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01610
01610  Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla

Coding Tips
For anesthesia provided during procedures on nerves, muscles, tendons, fascia, and bursae of the upper arm, see code 01710. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.
hemarthrosis. Occurrence of blood within a joint space.
Hodgkin's disease. Malignant disorder characterized by the presence of progressively swollen lymph nodes.
lymph nodes. Bean-shaped structures along the lymphatic vessels that intercept and destroy foreign materials in the tissue and bloodstream.
lymphadenitis. Inflammation of the lymph nodes.
neuropathy. Abnormality, disease, or malfunction of the nerves.
tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

Surgical to Anesthesia Code Crosswalk
0299T, 11011, 11043, 15736, 15758, 20005, 20200, 20205, 20206, 20520, 20525, 20555, 20950, 23000, 23020, 23030, 23031, 23066, 23073, 23076, 23077, 23078, 23333, 23395, 23397, 23405, 23406, 23410, 23412, 23440, 38300, 38305, 38308, 38500, 38525, 38550, 38555, 38740, 38745, 64575, 64577, 64580, 64585, 64713, 64722, 64784, 64788, 64790, 64792, 64795, 64861, 64892, 64893, 64897, 64898, 64905, 64907, 64910, 64911, 52114

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint

**Coding Tips**

This code represents anesthesia provided during closed surgical procedures. For anesthesia provided at the time of open surgical procedures, see codes 01630-01638. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- **acromioclavicular joint.** Junction between the clavicle and the scapula. The acromion is the projection from the back of the scapula that forms the highest point of the shoulder and connects with the clavicle. Trauma or injury to the acromioclavicular joint is often referred to as a dislocation of the shoulder. This is not correct, however, as a dislocation of the shoulder is a disruption of the glenohumeral joint. **Synonym(s):** AC joint.
- **closed fracture.** Break in a bone without a concomitant opening in the skin.
- **dislocation.** Displacement of a bone in relation to its neighboring tissue, especially a joint.
- **joint.** Area of contact, or juncture, between two or more bones, often articulating with each other.
- **sprain and strain.** Injuries to a joint, in which the fibers of supporting ligaments or muscles are overstretched or slightly ruptured, with the ligaments and muscles maintaining continuity.

**Surgical to Anesthesia Code Crosswalk**

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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-4,4,250.3,2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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**Base Unit Work Value Non-Fac PE Fac PE Malpractice Non-Fac Total Fac Total**

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Anesthesia for diagnostic arthroscopic procedures of shoulder joint

Coding Tips
For anesthesia at the time of a surgical arthroscopy or an open procedure of the shoulder, see code 01630. When diagnostic and surgical arthroscopy are performed at the same surgical session, the anesthesia for the diagnostic arthroscopy is included in the surgical arthroscopy code.

Surgical to Anesthesia Code Crosswalk
29805, 29815

ICD-9-CM Diagnostic Codes
213.4 Benign neoplasm of scapula and long bones of upper limb
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
446.0 Polyarteritis nodosa
710.0 Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)
710.1 Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)
710.2 Sicca syndrome
711.01 Pyogenic arthritis, shoulder region — (Use additional code to identify infectious organism: 041.0-041.8)
712.11 Chondrocalcinosis due to dicalcium phosphate crystals, shoulder region — (Code first underlying disease: 275.4)
712.21 Chondrocalcinosis due to pyrophosphate crystals, shoulder region — (Code first underlying disease: 275.4)
714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)
715.11 Primary localized osteoarthritis, shoulder region
715.21 Secondary localized osteoarthritis, shoulder region
716.11 Traumatic arthropathy, shoulder region
718.01 Articular cartilage disorder, shoulder region
718.21 Pathological dislocation of shoulder joint
718.31 Recurrent dislocation of shoulder joint
718.41 Contracture of shoulder joint
718.71 Developmental dislocation of joint, shoulder region
719.01 Effusion of shoulder joint
719.11 Herniation, shoulder region
719.21 Villonodular synovitis, shoulder region
719.31 Palindromic rheumatism, shoulder region
719.41 Pain in joint, shoulder region
719.51 Stiffness of joint, not elsewhere classified, shoulder region
726.0 Adhesive capsulitis of shoulder
726.11 Calcifying tendinitis of shoulder
726.12 Bicipital tendinitis

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3,2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

Coding Tips
For anesthesia at the time of a diagnostic arthroscopy, see code 01622. When diagnostic arthroscopy precedes the surgical arthroscopy at the same operative session, only the surgical arthroscopy should be coded. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **acromioclavicular joint**: Junction between the clavicle and the scapula. The acromion is the projection from the back of the scapula that forms the highest point of the shoulder and connects with the clavicle. Trauma or injury to the acromioclavicular joint is often referred to as a dislocation of the shoulder. This is not correct, however, as a dislocation of the shoulder is a disruption of the glenohumeral joint. Synonym(s): AC joint.
- **arthroscopy**: Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).
- **joint**: Area of contact, or juncture, between two or more bones, often articulating with each other.

Surgical to Anesthesia Code Crosswalk

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

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Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation

interthoraciscapular (forequarter) amputation

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
disarticulation. Removal of a limb through a joint.

Surgical to Anesthesia Code Crosswalk
23900, 23920

ICD-9-CM Diagnostic Codes
170.4 Malignant neoplasm of scapula and long bones of upper limb
171.2 Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
199.0 Disseminated malignant neoplasm
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
728.86 Necrotizing fasciitis — (Use additional code to identify infectious organism, 041.00-041.89, 785.4, if applicable)
785.4 Gangrene — (Code first any associated underlying condition)
880.10 Open wound of shoulder region, complicated
880.12 Open wound of axillary region, complicated
880.13 Open wound of upper arm, complicated
880.19 Open wound of multiple sites of shoulder and upper arm, complicated
880.20 Open wound of shoulder region, with tendon involvement
880.22 Open wound of axillary region, with tendon involvement
880.23 Open wound of upper arm, with tendon involvement
880.29 Open wound of multiple sites of shoulder and upper arm, with tendon involvement
887.2 Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication
887.3 Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated
906.7 Late effect of burn of other extremities
908.6 Late effect of certain complications of trauma

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01638

01638 Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement

**Coding Tips**

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

### Surgical to Anesthesia Code Crosswalk

23332, 23472, 23473, 23474

### ICD-9-CM Diagnostic Codes

- **446.0** Polyarteritis nodosa
- **710.0** Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)
- **710.1** Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)
- **714.0** Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)
- **715.11** Primary localized osteoarthrosis, shoulder region
- **715.21** Secondary localized osteoarthrosis, shoulder region
- **716.11** Traumatic arthropathy, shoulder region
- **727.61** Complete rupture of rotator cuff
- **730.11** Chronic osteomyelitis, shoulder region — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
- **730.12** Chronic osteomyelitis, upper arm — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
- **733.41** Aseptic necrosis of head of humerus — (Use additional code to identify major osseous defect, if applicable: 731.3)
- **733.81** Malunion of fracture
- **733.82** Nonunion of fracture
- **880.10** Open wound of shoulder region, complicated
- **927.00** Crushing injury of shoulder region — (Use additional code to identify any associated injuries: 800-829, 850.0-854.1, 860.0-869.1)
- **996.41** Mechanical loosening of prosthetic joint — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)
- **996.42** Dislocation of prosthetic joint — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

### IOM References

100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

### CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**Coding Tips**

Correct code assignment is determined by the type of surgical procedure performed. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- **aneurysm.** Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.
- **arteriovenous fistula.** Connecting passage between an artery and a vein.
- **atherosclerosis.** Buildup of yellowish plaques composed of cholesterol and lipoid material within the arteries.
- **autologous.** Tissue or structure derived from the same individual.
- **axillary.** Area under the arm.
- **bypass graft.** Surgically created alternative blood vessel used to reroute blood flow around an area of obstruction or disease.
- **embolism.** Obstruction of a blood vessel resulting from a clot or foreign substance.
- **stricture.** Narrowing of an anatomical structure.
- **thrombosis.** Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

**Surgical to Anesthesia Code Crosswalk**

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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

- 100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for all procedures on veins of shoulder and axilla

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
34490, 35206, 35236, 35266, 35460, 35875, 35876

ICD-9-CM Diagnostic Codes
440.30 Atherosclerosis of unspecified bypass graft of extremities
440.31 Atherosclerosis of autologous vein bypass graft of extremities
440.32 Atherosclerosis of nonautologous biological bypass graft of extremities
443.89 Other peripheral vascular disease
451.89 Phlebitis and thrombophlebitis of other site — (Use additional E code to identify drug, if drug-induced)
453.83 Acute venous embolism and thrombosis of upper extremity, unspecified
453.9 Embolism and thrombosis of unspecified site
459.2 Compression of vein
459.81 Unspecified venous (peripheral) insufficiency — (Use additional code for any associated ulceration: 707.10-707.19, 707.8, 707.9)
459.89 Other specified circulatory system disorders
747.63 Congenital upper limb vessel anomaly
747.69 Congenital anomaly of other specified site of peripheral vascular system
901.3 Innominate and subclavian vein injury
903.02 Axillary vein injury
903.1 Brachial blood vessels injury
903.8 Injury to specified blood vessels of upper extremity, other
996.74 Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)
997.79 Vascular complications of other vessels — (Use additional code to identify complications)
998.2 Accidental puncture or laceration during procedure

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Anesthesia for shoulder cast application, removal or repair; not otherwise specified

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
29049, 29055, 29058, 29065, 29105, 29583, 29710, 29730, 29740

ICD-9-CM Diagnostic Codes
714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)
718.71 Developmental dislocation of joint, shoulder region
718.82 Other joint derangement, not elsewhere classified, upper arm
733.81 Malunion of fracture
733.82 Nonunion of fracture
810.01 Closed fracture of sternal end of clavicle
810.02 Closed fracture of shaft of clavicle
810.03 Closed fracture of acromial end of clavicle
811.00 Closed fracture of unspecified part of scapula
811.01 Closed fracture of acromial process of scapula
811.02 Closed fracture of coracoid process of scapula
811.03 Closed fracture of glenoid cavity and neck of scapula
811.09 Closed fracture of other part of scapula
811.10 Open fracture of unspecified part of scapula
811.11 Open fracture of acromial process of scapula
811.12 Open fracture of coracoid process
811.13 Open fracture of glenoid cavity and neck of scapula
811.19 Open fracture of other part of scapula
812.00 Closed fracture of unspecified part of upper end of humerus
812.01 Closed fracture of surgical neck of humerus
812.02 Closed fracture of anatomical neck of humerus
812.03 Closed fracture of greater tuberosity of humerus
812.09 Other closed fractures of upper end of humerus
831.01 Closed anterior dislocation of humerus
831.02 Closed posterior dislocation of humerus
831.03 Closed inferior dislocation of humerus
831.04 Closed dislocation of acromioclavicular (joint)
831.09 Closed dislocation of other site of shoulder
840.0 Acromioclavicular (joint) (ligament) sprain and strain
840.1 Coracoclavicular (ligament) sprain and strain
840.2 Coracohumeral (ligament) sprain and strain
840.3 Infraspinatus (muscle) (tendon) sprain and strain
840.4 Rotator cuff (capsule) sprain and strain
840.5 Subscapularis (muscle) sprain and strain
840.6 Supraspinatus (muscle) (tendon) sprain and strain
840.8 Sprain and strain of other specified sites of shoulder and upper arm
V54.11 Aftercare for healing traumatic fracture of upper arm
V54.19 Aftercare for healing traumatic fracture of other bone
V54.21 Aftercare for healing pathologic fracture of upper arm
V54.29 Aftercare for healing pathologic fracture of other bone
V67.4 Treatment of healed fracture follow-up examination

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01710
0171 Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.
fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
polyarteritis nodosa. Systemic necrotizing vasculitis of small and medium arteries that results in the infarction and scarring within the affected organs.
polynephropathy. Disease process of severe inflammation of multiple nerves.
pressure ulcers. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off, caused by continual pressure impeding blood circulation, especially over bony areas, when a patient lies still for too long without changing position.
tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

Surgical to Anesthesia Code Crosswalk
11011, 11043, 15736, 15758, 20005, 20200, 20205, 20206, 20520, 20525, 20555, 20924, 20950, 23931, 24066, 24073, 24076, 24105, 24201, 24301, 24305, 24330, 24331, 24332, 24340, 24341, 24342, 24343, 24344, 24345, 24346, 24350, 24351, 24352, 24354, 24357, 24935, 24940, 64575, 64577, 64580, 64585, 64708, 64718, 64722, 64784, 64788, 64790, 64795, 64856, 64857, 64892, 64893, 64897, 64898, 64905, 64907, 64910, 64911

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
Tenodesis. Stabilization of a joint by anchoring tendons.
Tenoplasty. Surgical repair of a tendon defect.
Tenotomy. Cutting into a tendon.

Surgical to Anesthesia Code Crosswalk
23430, 24310, 24320, 24330, 24331, 24358, 24359

ICD-9-CM Diagnostic Codes
343.0 Diplegic infantile cerebral palsy
716.51 Unspecified polyarthropathy or polyarthritis, shoulder region
716.52 Unspecified polyarthropathy or polyarthritis, upper arm
718.32 Recurrent dislocation of upper arm joint
718.41 Contracture of shoulder joint
718.42 Contracture of upper arm joint
718.51 Ankylosis of joint of shoulder region
718.52 Ankylosis of upper arm joint
718.81 Other joint derangement, not elsewhere classified, shoulder region
718.82 Other joint derangement, not elsewhere classified, upper arm
718.91 Unspecified derangement, shoulder region
718.92 Unspecified derangement, upper arm joint
719.42 Pain in joint, upper arm
719.61 Other symptoms referable to shoulder joint
726.12 Bicipital tendosynovitis
728.3 Other specific muscle disorders
840.8 Sprain and strain of other specified sites of shoulder and upper arm
881.21 Open wound of elbow, with tendon involvement
927.03 Crushing injury of upper arm — (Use additional code to identify any associated injuries: 800-829, 850.0-854.1, 860.0-869.1)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01730

01730  Anesthesia for all closed procedures on humerus and elbow

Coding Tips
This code represents anesthesia provided during closed surgical procedures. For anesthesia at the time of a diagnostic arthroscopy, see code 01732; at the time of open or surgical arthroscopic procedures, see codes 01740-01748. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
arthropathy. Disease of the joints.
closed fracture. Break in a bone without a concomitant opening in the skin.
dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.
synovitis. Inflammation of the synovial membrane that lines a synovial joint, resulting in pain and swelling.

Surgical to Anesthesia Code Crosswalk
0102T, 20220, 20615, 20692, 24220, 24300, 24500, 24505, 24530, 24535, 24538, 24560, 24565, 24566, 24576, 24577, 24582, 24605, 24620, 24640, 24650

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for diagnostic arthroscopic procedures of elbow joint

**Coding Tips**

For anesthesia services provided at the time of an open procedure or surgical arthroscopy, see code 01740. Surgical arthroscopy includes diagnostic arthroscopy. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- **arthroscopy.** Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).
- **joint.** Area of contact, or juncture, between two or more bones, often articulating with each other.

**Surgical to Anesthesia Code Crosswalk**

**ICD-9-CM Diagnostic Codes**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>170.4</td>
<td>Malignant neoplasm of scapula and long bones of upper limb</td>
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<td>195.4</td>
<td>Malignant neoplasm of upper limb</td>
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<td>213.4</td>
<td>Benign neoplasm of scapula and long bones of upper limb</td>
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<tr>
<td>215.2</td>
<td>Other benign neoplasm of connective and other soft tissue of upper limb, including shoulder</td>
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<tr>
<td>238.0</td>
<td>Neoplasm of uncertain behavior of bone and articular cartilage</td>
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<td>239.2</td>
<td>Neoplasms of unspecified nature of bone, soft tissue, and skin</td>
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<td>275.40</td>
<td>Unspecified disorder of calcium metabolism — (Use additional code to identify any associated intellectual disabilities)</td>
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<td>275.41</td>
<td>Hypocalcemia — (Use additional code to identify any associated intellectual disabilities)</td>
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<td>275.42</td>
<td>Hypercalcemia — (Use additional code to identify any associated intellectual disabilities)</td>
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<td>275.49</td>
<td>Other disorders of calcium metabolism — (Use additional code to identify any associated intellectual disabilities)</td>
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<td>357.1</td>
<td>Polynuropathy in collagen vascular disease — (Code first underlying disease: 446.0, 710.0, 714.0)</td>
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<td>359.6</td>
<td>Symptomatic inflammatory myopathy in diseases classified elsewhere — (Code first underlying disease: 135, 140.0-208.9, 277.30-277.39, 446.0, 710.0, 710.1, 710.2, 714.0)</td>
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<td>446.0</td>
<td>Polyarteritis nodosa</td>
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01740

Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified

Coding Tips

For anesthesia at the time of a diagnostic arthroscopy, see code 01732. Anesthesia provided at the time of closed surgical procedures is reported using code 01730. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

arthroscopy. Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).
cellulitis. Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.
granuloma. Abnormal, dense collections or cells forming a mass or nodule of chronically inflamed tissue with granulations that is usually associated with an infective process.
joint. Area of contact, or juncture, between two or more bones, often articulating with each other.
pressure ulcers. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off, caused by continual pressure impeding blood circulation, especially over bony areas, when a patient lies still for too long without changing position.

Surgical to Anesthesia Code Crosswalk

11012, 11044, 20150, 20240, 20245, 20650, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 23930, 23935, 24000, 24006, 24100, 24101, 24102, 24120, 24125, 24126, 24130, 24134, 24136, 24138, 24140, 24145, 24147, 24155, 24160, 24164, 24343, 24345, 24360, 24361, 24362, 24365, 24366, 24470, 24498, 24515, 24516, 24545, 24546, 24575, 24579, 24586, 24587, 24615, 24635, 24665, 24666, 24685, 24802, 24935, 24940, 29834, 29835, 29836, 29837, 29838

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,4,250.3,2,100-4,12,140.1,100-4,12,140.3,100-4,12,140.3,3,100-4,12,140.3,100-4,12,140.3,4,100-4,12,140.4,1,100-4,12,140.4,2,100-4,12,140.4,3,100-4,12,140.4,4

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01742-01744
01742 Anesthesia for open or surgical arthroscopic procedures of the elbow; osteotomy of humerus
01744 repair of nonunion or malunion of humerus

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk
11044, 24400, 24410, 24420, 24430, 24435

ICD-9-CM Diagnostic Codes
11044 Multiple and unspecified open wound of upper limb, complicated
11046 Multiple and unspecified open wound of lower limb, complicated
11047 Other wound of upper limb, unspecified site, complicated
11048 Other wound of lower limb, unspecified site, complicated
11049 Open wound of upper limb, unspecified site, complicated
11051 Open wound of lower limb, unspecified site, complicated

Coding and Payment Guide for Anesthesia Services
Procedure Codes

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Anesthesia for open or surgical arthroscopic procedures of the elbow, radical procedures

Coding Tips
Use this code only when documentation indicates extensive surgical procedures.

Surgical to Anesthesia Code Crosswalk
24077, 24079, 24149, 24150, 24151, 24152, 24153, 24800, 24900, 24920, 24930, 24931, 24935

ICD-9-CM Diagnostic Codes
170.4 Malignant neoplasm of scapula and long bones of upper limb
171.2 Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
198.5 Secondary malignant neoplasm of bone and bone marrow
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
249.71 Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled — (Use additional code to identify any associated injuries: 249.71, 242.76)
250.71 Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled — (Use additional code to identify manifestation: 250.71, 242.76)
440.24 Atherosclerosis of native arteries of the extremities with gangrene — (Use additional code for any associated ulceration: 440.24, 242.76)
444.21 Embolism and thrombosis of arteries of upper extremity
445.01 Atheroembolism of upper extremity
711.02 Pyogenic arthritis, upper arm — (Use additional code to identify infectious organism: 711.02, 71.52)
714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 714.0, 71.52)
718.52 Ankylosis of upper joint arm
719.22 Villonodular synovitis, upper arm
728.86 Necrotizing fasciitis — (Use additional code to identify infectious organism, 728.86, 71.52)
730.12 Atherosclerosis of native arteries of the extremities with gangrene — (Use additional code for any associated ulceration: 730.12, 71.52)
730.22 Villonodular synovitis, upper arm
738.4 Gangrene — (Code first any associated underlying condition)
880.13 Open wound of upper arm, complicated
880.23 Open wound of upper arm, with tendon involvement

887.2 Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication
887.3 Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated
887.6 Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), without mention of complication
887.7 Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated
927.03 Crushing injury of upper arm — (Use additional code to identify any associated injuries: 800-829, 850.0-854.1, 860.0-869.1)
927.11 Crushing injury of elbow — (Use additional code to identify any associated injuries: 800-829, 850.0-854.1, 860.0-869.1)
943.52 Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of a body part
943.53 Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper a body part

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Fac Total: Non-Fac Total: Malpractice: Fac PE: Non-Fac PE: Work Value: Base Unit: 01756: 6.00: 0.00: 0.00: 0.00: 0.00: 0.00

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01758
Anesthesia for open or surgical arthroscopic procedures of the elbow; excision of cyst or tumor of humerus

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
aneurysmal bone cyst. Solitary bone lesion that bulges into the periosteum, marked by a calcified rim.
cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.
extcision. Surgical removal of an organ or tissue.
exostosis. Abnormal formation of a benign bony growth.
scapula. Triangular bone commonly referred to as the shoulder blade.
soft tissue. Nonepithelial tissues outside of the skeleton.
tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

Surgical to Anesthesia Code Crosswalk
20245, 24110, 24115, 24116

ICD-9-CM Diagnostic Codes
213.4 Benign neoplasm of scapula and long bones of upper limb
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
726.91 Exostosis of unspecified site
733.21 Solitary bone cyst
733.22 Aneurysmal bone cyst
733.29 Other cyst of bone

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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**Anesthesia for open or surgical arthroscopic procedures of the elbow; total elbow replacement**

**Coding Tips**
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**
- Joint replacement: Insertion of new substitute material in place of damaged or diseased joint tissue to restore function and movement.

**Surgical to Anesthesia Code Crosswalk**
24363, 24370, 24371

**ICD-9-CM Diagnostic Codes**

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<td>Polyneuropathy in collagen vascular disease — (Code first underlying disease: 446.0, 710.0, 714.0)</td>
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<td>359.6</td>
<td>Symptomatic inflammatory myopathy in diseases classified elsewhere — (Code first underlying disease: 135, 140.0-208.9, 277.30-277.39, 446.0, 710.0, 710.1, 710.2, 714.0)</td>
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<td>446.0</td>
<td>Polyarteritis nodosa</td>
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<td>710.0</td>
<td>Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)</td>
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<td>710.1</td>
<td>Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)</td>
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<td>710.2</td>
<td>Sicca syndrome</td>
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<td>711.02</td>
<td>Pyogenic arthritis, upper arm — (Use additional code to identify infectious organism: 041.0-041.8)</td>
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<td>711.92</td>
<td>Unspecified infective arthritis, upper arm</td>
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<td>714.0</td>
<td>Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)</td>
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<td>715.12</td>
<td>Primary localized osteoarthrosis, upper arm</td>
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<td>715.32</td>
<td>Localized osteoarthrosis not specified whether primary or secondary, upper arm</td>
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<td>716.12</td>
<td>Traumatic arthropathy, upper arm</td>
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<td>719.22</td>
<td>Villonodular synovitis, upper arm</td>
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<td>730.12</td>
<td>Chronic osteomyelitis, upper arm — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)</td>
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<td>Unspecified osteomyelitis, upper arm — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)</td>
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<td>730.32</td>
<td>Periostitis, without mention of osteomyelitis, upper arm — (Use additional code to identify organism: 041.1)</td>
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<td>730.82</td>
<td>Other infections involving bone diseases classified elsewhere, upper arm — (Use additional code to identify organism: 041.1. Code first underlying disease: 002.0, 015.0-015.9)</td>
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<tr>
<td>731.0</td>
<td>Osteitis deformans without mention of bone tumor</td>
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<td>733.49</td>
<td>Aseptic necrosis of other bone site — (Use additional code to identify major osseous defect, if applicable: 731.3)</td>
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<tr>
<td>733.82</td>
<td>Nonunion of fracture</td>
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<td>736.00</td>
<td>Unspecified deformity of forearm, excluding fingers</td>
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<td>754.89</td>
<td>Other specified nonteratogenic anomalies</td>
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<tr>
<td>756.51</td>
<td>Osteogenesis imperfecta</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**
100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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ICD-9-CM Diagnostic Codes

249.71 Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4) (Use additional code to identify any associated insulin use: V58.67)

250.71 Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

250.72 Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

250.73 Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled — (Use additional code to identify manifestation: 443.81, 785.4)

440.21 Atherosclerosis of native arteries of the extremities with intermittent claudication

440.22 Atherosclerosis of native arteries of the extremities with rest pain

440.23 Atherosclerosis of native arteries of the extremities with ulceration — (Use additional code for any associated ulceration: 707.10-707.19, 707.8, 707.9)

440.24 Atherosclerosis of native arteries of the extremities with gangrene — (Use additional code for any associated ulceration: 707.10-707.19, 707.8, 707.9)

440.30 Atherosclerosis of unspecified bypass graft of extremities

440.31 Atherosclerosis of autologous vein bypass graft of extremities

440.32 Atherosclerosis of nonautologous biological bypass graft of extremities

442.0 Aneurysm of artery of upper extremity

442.82 Aneurysm of subclavian artery

442.89 Aneurysm of other specified artery

443.0 Raynaud's syndrome — (Use additional code to identify gangrene: 785.4)

443.1 Thrombocytopenia obliterans (Buerger's disease)

443.81 Peripheral angiopathy in diseases classified elsewhere — (Code first underlying disease: 249.7, 250.7)

444.21 Embolism and thrombosis of arteries of upper extremity

444.89 Embolism and thrombosis of other specified artery

445.01 Atheroembolism of upper extremity

445.89 Atheroembolism of other site

447.0 Arteriovenous fistula, acquired

447.1 Stricture of artery

447.2 Rupture of artery

881.10 Open wound of forearm, complicated

903.01 Axillary artery injury

903.1 Brachial blood vessels injury

903.2 Radial blood vessels injury

903.3 Ulnar blood vessels injury

908.3 Late effect of injury to blood vessel of head, neck, and extremities

996.1 Mechanical complication of other vascular device, implant, and graft

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4, 250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01780

Anesthesia for procedures on veins of upper arm and elbow; not otherwise specified

Coding Tips

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

arteriovenous fistula. Connecting passage between an artery and a vein.
atherosclerosis. Buildup of yellowish plaques composed of cholesterol and lipid material within the arteries.
autologous. Tissue or structure derived from the same individual.
embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.

Surgical to Anesthesia Code Crosswalk

35184, 35190, 35206, 35236, 35266, 35460, 35875, 35876, 36834

ICD-9-CM Diagnostic Codes

440.30 Atherosclerosis of unspecified bypass graft of extremities
440.31 Atherosclerosis of autologous vein bypass graft of extremities
440.32 Atherosclerosis of nonautologous biological bypass graft of extremities
443.89 Other peripheral vascular disease
444.21 Embolism and thrombosis of arteries of upper extremity
447.0 Arteriovenous fistula, acquired
453.9 Embolism and thrombosis of unspecified site
459.2 Compression of vein
459.81 Unspecified venous (peripheral) insufficiency — (Use additional code for any associated ulceration: 707.10-707.19, 707.8, 707.9)
459.89 Other specified circulatory system disorders
747.60 Congenital anomaly of the peripheral vascular system, unspecified site
747.63 Congenital upper limb vessel anomaly
747.69 Congenital anomaly of other specified site of peripheral vascular system
903.02 Axillary vein injury
903.1 Brachial blood vessels injury
903.2 Radial blood vessels injury
903.3 Ulnar blood vessels injury
903.8 Injury to specified blood vessels of upper extremity, other

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CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

IOM References

100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

Note: This list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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01782
Anesthesia for procedures on veins of upper arm and elbow; phleborrhaphy

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
-rrhapy. Repair.
dissection. Separating by cutting tissue or body structures apart.
laceration. Tearing injury; a torn, ragged-edged wound.
phlebo-. Relating to the vein.
puncture. Creating a hole.
rupture. Tearing or breaking open of tissue.

Surgical to Anesthesia Code Crosswalk
35206

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01810

01810  Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- arthrodesis. Surgical fixation or fusion of a joint to reduce pain and improve stability, performed openly or arthroscopically.
- avulsion. Forcible tearing away of a part, by surgical means or traumatic injury.
- bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.
- carpal tunnel. Anatomical landmark referring to the space in the wrist on the palmar side that houses the median nerve and all nine of the flexor tendons serving the fingers and thumb. The space is created by the bones of the wrist on either side and a thick ligament called the transverse carpal ligament.
- fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
- neuroplasty. Surgical release of adhesions around a nerve carried out to relieve pain and disability.
- tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vascuature.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01820

Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones

**Coding Tips**

This code represents anesthesia provided during closed procedures on the radius, ulna, wrist, or hand bones. For anesthesia during diagnostic arthroscopic procedures, see code 01829. For anesthesia during open or surgical arthroscopy, see codes 01830-01832. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

closed fracture. Break in a bone without a concomitant opening in the skin.

dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.

enthesopathy. Disorders that occur at points where muscle tendons and ligaments attach to bones or joint capsules. Enthesopathy is reported with a code from ICD-9-CM category 726, dependent upon the location, or to 720.1 when affecting the spine.

pathologic fracture. Break in bone due to a disease process that weakens the bone structure, such as osteoporosis, osteomalacia, or neoplasia, and not traumatic injury.

stress fracture. Fracture of the bone caused by repetitive overuse. Frequently occurring in the setting of heavy physical labor, sports, or strenuous exercise, these fractures are particularly common in the metatarsal bones of the foot. Treatment consists of disuse, rest, and occasionally casting or splinting to avoid reinjury during the healing process. Report stress fractures with a code from ICD-9-CM subcategory 733.9, and personal history with V13.52.

synovitis. Inflammation of the synovial membrane that lines a synovial joint, resulting in pain and swelling.

**Surgical to Anesthesia Code Crosswalk**

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<th>Coding and Payment Guide for Anesthesia Services</th>
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**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

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01829

Anesthesia for diagnostic arthroscopic procedures on the wrist

Coding Tips
For anesthesia services provided at the time of a surgical arthroscopy, see code 01830. When diagnostic arthroscopy precedes the surgical arthroscopy at the same session, only the surgical arthroscopy should be coded.

Surgical to Anesthesia Code Crosswalk
29840, 29900

ICD-9-CM Diagnostic Codes
171.2 Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
215.2 Other benign neoplasm of connective and other soft tissue of upper limb, including shoulder
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
446.0 Polyarteritis nodosa
682.4 Cellulitis and abscess of hand, except fingers and thumb — (Use additional code to identify organism, such as 041.1, etc.)
711.04 Pyogenic arthritis, hand — (Use additional code to identify infectious organism: 041.0-041.8)
714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)
714.30 Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
714.31 Polyarticular juvenile rheumatoid arthritis, acute
715.23 Secondary localized osteoarthrosis, forearm
716.04 Kaschin-Beck disease, hand
716.13 Traumatic arthropathy, forearm
716.14 Traumatic arthropathy, hand
718.03 Articular cartilage disorder, forearm
718.23 Pathological dislocation of forearm joint
718.33 Recurrent dislocation of forearm joint
718.43 Contracture of forearm joint
718.74 Developmental dislocation of joint, hand
719.23 Villonodular synovitis, forearm
719.24 Villonodular synovitis, hand
728.82 Foreign body granuloma of muscle — (Use additional code to identify foreign body (V90.01-V90.9))
729.6 Residual foreign body in soft tissue — (Use additional code to identify foreign body (V90.01-V90.9))
730.04 Acute osteomyelitis, hand — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
730.14 Chronic osteomyelitis, hand — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
730.34 Periostitis, without mention of osteomyelitis, hand — (Use additional code to identify organism: 041.1)
730.84 Other infections involving diseases classified elsewhere, hand bone — (Use additional code to identify organism: 041.1. Code first underlying disease: 002.0, 015.0-015.9)
882.1 Open wound of hand except finger(s) alone, complicated
883.1 Open wound of finger(s), complicated

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01830

Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified

Coding Tips

For anesthesia services provided at the time of a diagnostic arthroscopy, see code 01829. When diagnostic arthroscopy precedes the surgical arthroscopy at the same session, only the surgical arthroscopy should be coded. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

arthroscopy. Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).

cellulitis. Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.

contracture. Shortening of muscle or connective tissue.

distal. Located farther away from a specified reference point.

endoscopy. Visual inspection of the body using a fiberoptic scope.

granuloma. Abnormal, dense collections or cells forming a mass or nodule of chronically inflamed tissue with granulations that is usually associated with an infective process.

polyneuropathy. Disease process of severe inflammation of multiple nerves.

rheumatoid arthritis. Autoimmune disease causing pain, stiffness, inflammation, and possibly joint destruction.

Surgical to Anesthesia Code Crosswalk

11012, 11044, 20150, 20240, 20650, 20670, 20680, 20690, 20692, 20693, 20694, 20696, 20697, 20900, 20975, 25035, 25040, 25100, 25101, 25105, 25119, 25120, 25125, 25126, 25130, 25135, 25136, 25145, 25150, 25151, 25170, 25210, 25215, 25220, 25230, 25240, 25250, 25251, 25332, 25335, 25337, 25350, 25355, 25360, 25365, 25370, 25375, 25390, 25391, 25392, 25393, 25394, 25400, 25405, 25415, 25420, 25425, 25426, 25430, 25431, 25440, 25441, 25442, 25443, 25444, 25445, 25447, 25449, 25450, 25455, 25459, 25465, 25491, 25492, 25515, 25525, 25526, 25545, 25587, 25607, 25608, 25609, 25620, 25628, 25645, 25651, 25652, 25670, 25671, 25676, 25685, 25695, 25800, 25805, 25810, 25820, 25825, 25830, 25900, 25905, 25909, 25915, 25920, 25924, 25927, 25931, 26034, 26035, 26070, 26075, 26080, 26100, 26105, 26110, 26115, 26200, 26205, 26210, 26215, 26230, 26235, 26236, 26250, 26255, 26260, 26261, 26262, 26320, 26525, 26530, 26531, 26535, 26536, 26546, 26555, 26562, 26565, 26567, 26568, 26580, 26585, 26587, 26590, 26615, 26665, 26685, 26686, 26713, 26735, 26746, 26765, 26785, 26820, 26841, 26842, 26843, 26844, 26850, 26852, 26860, 26862, 26910, 26951, 26952, 29843, 29844, 29845, 29846, 29847, 29848, 29901, 29902

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**Coding Tips**

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Surgical to Anesthesia Code Crosswalk**

25446

**ICD-9-CM Diagnostic Codes**

710.0  Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)

710.1  Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)

711.03 Pyogenic arthritis, forearm — (Use additional code to identify infectious organism: 041.0-041.8)

711.04 Pyogenic arthritis, hand — (Use additional code to identify infectious organism: 041.0-041.8)

714.0  Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)

715.13 Primary localized osteoarthrosis, forearm

715.14 Primary localized osteoarthrosis, hand

715.23 Secondary localized osteoarthrosis, forearm

715.24 Secondary localized osteoarthrosis, involving hand

715.33 Localized osteoarthrosis not specified whether primary or secondary, forearm

715.34 Localized osteoarthrosis not specified whether primary or secondary, hand

716.13 Traumatic arthropathy, forearm

716.14 Traumatic arthropathy, hand

718.83 Other joint derangement, not elsewhere classified, forearm

718.84 Other joint derangement, not elsewhere classified, hand

719.23 Villonodular synovitis, forearm

719.24 Villonodular synovitis, hand

719.63 Other symptoms referable to forearm joint

719.64 Other symptoms referable to hand joint

730.13 Chronic osteomyelitis, forearm — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)

730.14 Chronic osteomyelitis, hand — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)

730.23 Unspecified osteomyelitis, forearm — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)

730.24 Unspecified osteomyelitis, hand — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)

730.33 Periostitis, without mention of osteomyelitis, forearm — (Use additional code to identify organism: 041.1)

730.34 Periostitis, without mention of osteomyelitis, hand — (Use additional code to identify organism: 041.1)

731.0  Osteitis deformans without mention of bone tumor

733.49 Aseptic necrosis of other bone site — (Use additional code to identify major osseous defect, if applicable: 731.3)

733.82 Nonunion of fracture

756.51 Osteogenesis imperfecta

905.2  Late effect of fracture of upper extremities

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

**CCI Version 20.0**


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01840-01842

01840  Anesthesia for procedures on arteries of forearm, wrist, and hand; not otherwise specified

01842  embolectomy

**Coding Tips**
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**
- **embolectomy.** Surgical excision of a blood clot or other foreign material that broke away from its original source and traveled in the blood stream, becoming lodged in a blood vessel and blocking circulation.
- **emboilism.** Obstruction of a blood vessel resulting from a clot or foreign substance.
- **graft.** Tissue implant from another part of the body or another person.
- **implant.** Material or device inserted or placed within the body for therapeutic, reconstructive, or diagnostic purposes.

**Surgical to Anesthesia Code Crosswalk**

20805, 20808, 20816, 26111, 26113, 26115, 26116, 26551, 26553, 26554, 26556, 34111, 35045, 35184, 35190, 35206, 35207, 35236, 35523, 35761, 35860, 35875, 36140, 37607, 37618

**ICD-9-CM Diagnostic Codes**

453.73  Chronic venous embolism and thrombosis of upper extremity, unspecified — (Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61))

453.83  Acute venous embolism and thrombosis of upper extremity, unspecified

996.1  Mechanical complication of other vascular device, implant, and graft

996.74  Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**

100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)

Coding Tips
This code represents anesthesia provided during procedures for vascular shunt or shunt revisions. See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
ESRD. End stage renal disease. Progression of chronic renal failure to lasting and irreparable kidney damage that requires dialysis or renal transplant for survival.

nephritis. Inflammation of the kidney, often due to infection, metabolic disorder, or an autoimmune process.

revision. Reordering or rearrangement of tissue to suit a particular need or function.

shunt. Surgically created passage between blood vessels or other natural passages, such as an arteriovenous anastomosis, to divert or bypass blood flow from the normal channel.

vascular. Pertaining to blood vessels.

Surgical to Anesthesia Code Crosswalk
36145, 36147, 36800, 36810, 36815, 36819, 36820, 36821, 36823, 36825, 36830, 36831, 36832, 36833, 36835, 36838, 36860, 36861, 36870, 37607

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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01850-01852

01850  Anesthesia for procedures on veins of forearm, wrist, and hand; not otherwise specified
01852  phleborrhaphy

**Coding Tips**

See the Surgical to Anesthesia Crosswalk for a complete list of the surgical codes that are associated with these anesthesia services. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- rrhapy. Repair.
- atherosclerosis. Buildup of yellowish plaques composed of cholesterol and lipid material within the arteries.
- autologous. Tissue or structure derived from the same individual.
- embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.
- phlebo-. Relating to the vein.
- thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

**Surgical to Anesthesia Code Crosswalk**

26111, 26113, 26115, 26116, 35206, 35207, 35236, 35266, 35460, 35875, 35876, 36680

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Anesthesia for forearm, wrist, or hand cast application, removal, or repair

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
*arthropathy.* Disease of the joints.
*cast.* Rigid encasement or dressing molded to the body from a substance that hardens upon drying to hold a body part immobile during the healing period; a model or reproduction made from an impression or mold.
*malunion.* Fracture that has united in a faulty position due to inadequate reduction of the original fracture, insufficient holding of a previously well-reduced fracture, contracture of the soft tissues, or comminuted or osteoporotic bone causing a slow disintegration of the fracture.
*nondunion.* Failure of two ends of a fracture to mend or completely heal.
*pathologic fracture.* Break in bone due to a disease process that weakens the bone structure, such as osteoporosis, osteomalacia, or neoplasia, and not traumatic injury.
*removal.* Process of moving out of or away from, or the fact of being removed.
*tendon.* Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

Surgical to Anesthesia Code Crosswalk
29075, 29085, 29086, 29125, 29126, 29130, 29131, 29584, 29730, 29740

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for diagnostic arteriography/venography

Coding Tips
Anesthesia for diagnostic arteriography or venography should not be reported in conjunction with codes for therapeutic radiologic procedures. For therapeutic radiological procedures, see codes 01924-01926 and 01930-01933. Anesthesia provided at the time of a cardiac catheterization is reported using code 01920, during non-invasive imaging or radiation therapy report code 01922. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
arteriography. Radiologic study of an artery upon injection of dye.
diagnostic procedures. Procedure performed on a patient to obtain information to assess the medical condition of the patient or to identify a disease and to determine the nature and severity of an illness or injury.
venography. Radiographic study of the veins.

Surgical to Anesthesia Code Crosswalk
0338T, 0339T, 36000, 36005, 36010, 36011, 36012, 36100, 36120, 36147, 36200, 36221, 36222, 36223, 36224, 36225, 36226, 36245, 36246, 36247, 36251, 36252, 36253, 36254, 38200, 75671, 75746, 75840

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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01920

01920  Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)

Coding Tips
Anesthesia for diagnostic arteriography or venography should not be reported in conjunction with codes for therapeutic radiologic procedures. For therapeutic radiological procedures, see codes 01924-01926 and 01930-01933. Anesthesia provided at the time of arteriography or venography is reported using code 01916; during non-invasive imaging or radiation therapy report code 01922. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
angiography. Radiographic imaging of the arteries. Imaging may be performed to study the vasculature of any given organ, body system, or area of circulation such as the brain, heart, chest, kidneys, limbs, gastrointestinal tract, aorta, and pulmonary circulation to visualize the formation and the function of the blood vessels to detect problems such as a blockage or stricture. A catheter is inserted through an accessible blood vessel and the artery is injected with a radiopaque contrast material after which x-rays are taken.
catheterization. Use or insertion of a tubular device into a duct, blood vessel, hollow organ, or body cavity for injecting or withdrawing fluids for diagnostic or therapeutic purposes.
ventriculogram. Interventional procedure that demonstrates the contractility of the cardiac ventricles by serial recording of the distribution of intravenously injected radionuclide or that of radiographic contrast medium injected through an intracardiac catheter.

Surgical to Anesthesia Code Crosswalk
0031T, 0281T, 0293T, 0294T, 0343T, 0345T, 36013, 36014, 36015, 92975, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93501, 93505, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93546, 93561, 93562

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3,2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3,3; 100-4,12,140.3,4; 100-4,12,140.4,1; 100-4,12,140.4,2; 100-4,12,140.4,3; 100-4,12,140.4,4

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for non-invasive imaging or radiation therapy

Coding Tips

Anesthesia for diagnostic arteriography or venography should not be reported in conjunction with codes for therapeutic radiologic procedures. For therapeutic radiologic procedures, see codes 01924-01926 and 01930-01933. Anesthesia provided at the time of venography or arteriography is reported with code 01916; cardiac catheterization is reported using code 01920. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know

imaging. Radiologic means of producing pictures for clinical study of the internal structures and functions of the body, such as x-ray, ultrasound, magnetic resonance, or positron emission tomography.

noninvasive diagnostic test. Procedure that does not require insertion of an instrument or device through the skin or body orifice for diagnosis.

Surgical to Anesthesia Code Crosswalk


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

ICD-9-CM Diagnostic Codes

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Anesthesia for therapeutic interventional radiological procedures involving the arterial system; not otherwise specified

Coding Tips
Anesthesia for diagnostic arteriography or venography should not be reported in conjunction with codes for therapeutic radiologic procedures. For diagnostic radiological procedures, see codes 01916, 01920, and 01922. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.
congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
hemangioma. Benign neoplasm arising from vascular tissue or malformations of vascular structures. It is most commonly seen in children and infants as a tumor of newly formed blood vessels due to malformed fetal angioblastic tissues.
iatrogenic. Adversely induced in the patient; caused by medical treatment.
stenosis. Narrowing or constriction of a passage.
therapeutic services. Services performed for treatment of a specific diagnosis. These services include performance of the procedure, various incidental elements, and normal, related follow-up care.

Surgical to Anesthesia Code Crosswalk

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified

Coding Tips
Anesthesia for diagnostic arteriography or venography should not be reported in conjunction with codes for therapeutic radiologic procedures. For diagnostic radiological procedures, see codes 01916, 01920, and 01922. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **interventional radiology**: Performance of invasive procedures using imaging guidance.
- **lymphatic system**: Lymphatic capillaries, vessels, lymph nodes, spleen, thymus gland, and bone marrow.
- **therapeutic services**: Services performed for treatment of a specific diagnosis. These services include performance of the procedure, various incidental elements, and normal, related follow-up care.
- **venous**: Relating to the veins.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01931

Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intrahepatic or portal circulation (e.g., transvenous intrahepatic portosystemic shunt[s] [TIPS])

Coding Tips
Anesthesia for diagnostic arteriography or venography should not be reported in conjunction with codes for therapeutic radiologic procedures. For diagnostic radiological procedures, see codes 01916, 01920, and 01922. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
Intra. Within.
TIPS. Transvenous intrahepatic portosystemic shunt. Life-saving procedure to improve blood flow, prevent hemorrhage, and manage the complications of portal hypertension, such as recurrent variceal bleeding and refractory ascites. The shunt may be portocaval, placed between the portal vein and the subhepatic inferior vena cava (IVC) or mesocaval, between the superior mesenteric vein (SMV) and the IVC. This procedure is reported with CPT codes 37182-37183.

Surgical to Anesthesia Code Crosswalk
37182, 37183, 37200, 37203, 37241, 37243, 37244

ICD-9-CM Diagnostic Codes
452 Porta veion thrombosis
453.0 Budd-Chiari syndrome
456.0 Esophageal varices with bleeding
456.1 Esophageal varices without mention of bleeding
456.20 Esophageal varices with bleeding in diseases classified elsewhere — (Code first underlying disease: 571.0-571.9, 572.3)
456.21 Esophageal varices without mention of bleeding in diseases classified elsewhere — (Code first underlying disease: 571.0-571.9, 572.3)
459.2 Compression of vein
572.1 Portal pyemia
572.3 Portal hypertension — (Use additional code for any associated complications, such as: portal hypertensive gastropathy (537.89))
789.51 Malignant ascites
789.59 Other ascites

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Procedure Codes Coding and Payment Guide for Anesthesia Services

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Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); intrathoracic or jugular

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
arteriosclerosis. Condition causing thickening of the artery walls.
atherosclerosis. Buildup of yellowish plaques composed of cholesterol and lipid material within the arteries.
thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

Surgical to Anesthesia Code Crosswalk
37200, 37203, 37241, 37243, 37244

ICD-9-CM Diagnostic Codes
453.0 Budd-Chiari syndrome
453.3 Embolism and thrombosis of renal vein
996.1 Mechanical complication of other vascular device, implant, and graft

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic and therapeutic

Coding Tips

Codes 01935 and 01936 were developed specifically to reflect the differences in anesthesia work required for diagnostic versus therapeutic spinal procedures. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk

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ICD-9-CM Diagnostic Codes

170.2 Malignant neoplasm of vertebral column, excluding sacrum and coccyx
192.2 Malignant neoplasm of spinal cord
192.3 Secondary malignant neoplasm of brain and spinal cord
198.5 Secondary malignant neoplasm of bone and bone marrow
203.00 Multiple myeloma, without mention of having achieved remission
203.01 Multiple myeloma in remission
213.2 Benign neoplasm of vertebral column, excluding sacrum and coccyx
238.0 Neoplasm of uncertain behavior of bone and articular cartilage
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
353.1 Lumbosacral plexus lesions
721.1 Cervical spondylosis with myelopathy
721.3 Lumbosacral spondylosis without myelopathy
721.41 Spondylosis with myelopathy, thoracic region
721.42 Spondylosis with myelopathy, lumbar region
721.6 Ankylosing vertebral hyperostosis
721.7 Traumatic spondylosphy
722.31 Schmorl's nodes, thoracic region
722.32 Schmorl's nodes, lumbar region
722.4 Degeneration of cervical intervertebral disc
722.51 Degeneration of thoracic or thoracolumbar intervertebral disc
722.52 Degeneration of lumbar or lumbosacral intervertebral disc
722.71 Intervertebral cervical disc disorder with myelopathy, cervical region
722.72 Intervertebral thoracic disc disorder with myelopathy, thoracic region
722.73 Intervertebral lumbar disc disorder with myelopathy, lumbar region
722.82 Postlaminectomy syndrome, thoracic region
722.83 Postlaminectomy syndrome, lumbar region
731.0 Osteitis deformans without mention of bone tumor
733.01 Sickle cell anemia — (Use additional code to identify major osseous defect, if applicable: 733.1) (Use additional code to identify personal history of pathologic (healed) fracture: V1.3.51)
733.02 Idiopathic osteoporosis — (Use additional code to identify major osseous defect, if applicable: 733.1) (Use additional code to identify personal history of pathologic (healed) fracture: V1.3.51)
733.95 Stress fracture of other bone — (Use additional external cause code(s) to identify the cause of the stress fracture)
805.2 Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury
805.4 Closed fracture of lumbar vertebra without mention of spinal cord injury

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.
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:

- 01951 between 4% and 9% of total body surface area
- 01952 each additional 9% total body surface area or part thereof (List separately in addition to code for primary procedure)

**Coding Tips**

As an "add-on" code, 01953 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. For Medicare claims, code 01953 is paid for a base unit of 1 and no time units. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

debridement. Removal of dead or contaminated tissue and foreign matter from a wound.
dermis, the upper portion of the dermis, possibly some deeper dermal tissues, and blistering of the skin with fluid exudate.

TBSA. Total body surface area.

degree burn. Full-thickness burn with total destruction of the epidermis and dermis, while deeper underlying tissue may also be affected, including the loss of body parts (e.g., nose, ear, extremity).

Surgical to Anesthesia Code Crosswalk

15002, 15004, 16010, 16015

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References

100-4,12,140.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.4; 100-4,12,140.1.4; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01958
01958  Anesthesia for external cephalic version procedure

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
antepartum. Period of pregnancy between conception and the onset of labor.
breech presentation. Abnormal condition in which the fetal buttocks present first. In frank breech, the legs of the fetus extend over the abdomen and thorax so that the feet lie beside the face. In complete breech, the legs are flexed and crossed, while incomplete breech presents with one or both lower legs and feet prolapsed into the vagina.

Surgical to Anesthesia Code Crosswalk
59412

ICD-9-CM Diagnostic Codes
652.10 Breech or other malpresentation successfully converted to cephalic presentation, unspecified as to episode of care — (Code first any associated obstructed labor, 660.0)
652.11 Breech or other malpresentation successfully converted to cephalic presentation, delivered — (Code first any associated obstructed labor, 660.0)
652.13 Breech or other malpresentation successfully converted to cephalic presentation, antepartum — (Code first any associated obstructed labor, 660.0)
652.21 Breech presentation without mention of version, delivered — (Code first any associated obstructed labor, 660.0)
652.23 Breech presentation without mention of version, antepartum — (Code first any associated obstructed labor, 660.0)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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01960-01961
01960  Anesthesia for vaginal delivery only
01961  Anesthesia for cesarean delivery only

Coding Tips
Use code 01960 or 01961 regardless of the type of anesthesia provided. The type of anesthesia care (i.e., general, epidural, or spinal) does not affect code assignment. According to the AMA, code 01961 may be used when the patient undergoes a C-section, even if the patient presents with prolonged labor or failure to progress, as long as the patient has not received neuraxial analgesia (01968). Code 01961 is also appropriate to use in the case of a planned C-section. When a cesarean section is performed following neuraxial analgesia or anesthesia during labor for a planned vaginal delivery, code 01967 is reported for the analgesia or anesthesia services performed during the labor. Code 01968 is reported additionally as an add-on service for the anesthesia services related to the cesarean delivery. When a cesarean hysterectomy is performed following neuraxial labor analgesia/anesthesia, code 01969 is reported additionally as an add-on service for the anesthesia services related to the hysterectomy.

Terms To Know
cesarean section. Delivery of fetus by incision. classical c. Delivery of the fetus by an incision made in the upper part of the uterus, or corpus uteri, via an abdominal peritoneal approach. This type of delivery is performed when a vaginal delivery is not possible or advisable and is reported with ICD-9-CM procedure code 74.0. low cervical c. Delivery of the fetus by an incision in the lower segment of the uterus, either through a transperitoneal incision or extraperitoneally with the peritoneal fold being displaced upwards. Low cervical cesarean is reported with 74.1. Synonym(s): corporeal cesarean section, fundal cesarean section, lower uterine segment cesarean section, transverse cesarean section.
neuraxial anesthesia. Regional anesthesia injection into the spine primarily administered to maternity patients in labor.

Surgical to Anesthesia Code Crosswalk
59409, 59515, 59612, 59620

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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01962

01962  Anesthesia for urgent hysterectomy following delivery

Coding Tips
According to the AMA, this code reflects the anesthesia service for the urgent hysterectomy procedure only. Therefore, an additional code for anesthesia during delivery (01960, 01961, 01967) should be separately reported if performed by the same provider. Some payers may require that modifier 59 Distinct procedure, be appended to this code.

Terms To Know
-ectomy. Excision, removal.
delivery. Expulsion or extraction of a child and the afterbirth.
hyster(o)-. Relating to either the womb or hysteria.
hysterectomy. Surgical removal of the uterus. A complete hysterectomy may also include removal of tubes and ovaries.
urgent. Status of patient or patient care when delay would threaten the patient's life or well-being.

Surgical to Anesthesia Code Crosswalk
58150, 58180

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care

Coding Tips
When cesarean hysterectomy is performed following neuraxial labor analgesia/anesthesia, report code 01969. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
cesarean section. Delivery of fetus by incision made in the upper part of the uterus, or corpus uteri, via an abdominal peritoneal approach when a vaginal delivery is not possible or advisable; often referred to as a classic c-section. Low cervical approach is a type of c-section by an incision in the lower segment of the uterus, either through a transperitoneal incision or extraperitoneally with the peritoneal fold being displaced upwards.
neuraxial anesthesia. Regional anesthesia injection into the spine primarily administered to maternity patients in labor.
rupture. Tearing or breaking open of tissue.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01965-01966

01965  Anesthesia for incomplete or missed abortion procedures
01966  Anesthesia for induced abortion procedures

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
abortion. Premature expulsion or extraction of the products of conception.
missed abortion. Retention of a dead fetus within the uterus in cases where fetal demise occurred before 22 weeks gestation. Abortion in this context refers to retained products of conception from the death of a normal fetus that does not result in spontaneous or induced abortion, or missed delivery.
papyraceous fetus. Fetus that has died, but remains in utero for weeks before delivery, becoming compacted and mummified in appearance, with skin resembling parchment. This condition occurs most commonly in multigestational pregnancies in which one of the fetuses dies or intentional multigestational reduction is carried out to save another more viable fetus. Papyraceous fetus is reported with ICD-9-CM subcategory 646.0, while multiple gestation codes denoting the pregnancy with fetal loss and retention of one or more fetuses are reported under category 651. Synonym(s): paper doll fetus.

Surgical to Anesthesia Code Crosswalk
59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260, S2265, S2266, S2267

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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CCI Version 20.0

Also not with 01966: 01965
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
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)

**Coding Tips**

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

**Terms To Know**

- **Epidural.** Anesthesia commonly used during labor and delivery achieved by the injection of an anesthetic agent between the vertebrae into the extradural space.
- **Neruaxial anesthesia.** Regional anesthesia injection into the spine primarily administered to maternity patients in labor.
- **Subarachnoid.** Located below the arachnoid meningeal layer.

**Surgical to Anesthesia Code Crosswalk**

59409, 59514, 59515

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01968

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

Coding Tips
As an add-on code, 01968 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. For Medicare purposes, add-on code 01968 is paid at a rate of 2 base units and no additional time.

Terms To Know
neuraxial anesthesia. Regional anesthesia injection into the spine primarily administered to maternity patients in labor.

Surgical to Anesthesia Code Crosswalk
59514, 59515

ICD-9-CM Diagnostic Codes
The ICD-9-CM diagnostic code(s) would be the same as the actual procedure performed because these are in-addition-to codes.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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

Coding Tips
As an "add-on" code, 01969 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure and must never be reported as a stand-alone code. For Medicare purposes, add-on code 01969 is paid at a rate of 5 base units and no additional time.

Terms To Know
-ectomy. Excision, removal.
*hyster(o)-. Relating to either the womb or hysteria.
neuraxial anesthesia. Regional anesthesia injection into the spine primarily administered to maternity patients in labor.

ICD-9-CM Diagnostic Codes
The ICD-9-CM diagnostic code(s) would be the same as the actual procedure performed because these are in-addition-to codes.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Physiological support for harvesting of organ(s) from brain-dead patient

Coding Tips
The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
harvest. Removal of cells or tissue from their native site to be used as a graft or transplant to another part of the donor's body or placed into another person.

Surgical to Anesthesia Code Crosswalk
32850, 33930, 33940, 44132, 44135, 47133, 48550, 50300

ICD-9-CM Diagnostic Codes
V59.4  Kidney donor
V59.6  Liver donor
V59.8  Donor of other specified organ or tissue
Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,250.3.2; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
01991-01992

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

01992  prone position

Coding Tips
This procedure may be performed by a physician or other qualified health care professional. Check with the specific payer to determine coverage. Codes 01991 and 01992 reflect anesthesia services when a therapeutic nerve block or injection is performed by a different provider. These codes should not be reported in addition to codes 99143–99150.

Terms To Know
nerve block. Regional anesthesia/analgesia administered by injection that prevents sensory nerve impulses from reaching the central nervous system.
prone. Lying face downward.

Surgical to Anesthesia Code Crosswalk
20612, 63600, 63610, 63615

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4, 12, 140.1; 100-4, 12, 140.3; 100-4, 12, 140.3.3; 100-4, 12, 140.3.4; 100-4, 12, 140.4.1; 100-4, 12, 140.4.2; 100-4, 12, 140.4.3; 100-4, 12, 140.4.4

CCI Version 20.0

Also not with 01991: 01992
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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01996

Daily hospital management of epidural or subarachnoid continuous drug administration

Coding Tips
This code should be used to report the daily management of pain postoperatively when the catheter was placed primarily for anesthesia administration during the operative session.

Terms To Know
epidural. Anesthesia commonly used during labor and delivery achieved by the injection of an anesthetic agent between the vertebrae into the extradural space.
subarachnoid. Located below the arachnoid meningeal layer.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,4,250.3; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

CCI Version 20.0
93312-93313, 93561-93562, 93701, 99143-99149, 99150, C8921-C8927
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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20526

20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

Explanation
A physician administers a single therapeutic injection of corticosteroid or anesthetic, 4 cm proximal to the wrist crease between the tendons of the radial flexor and the long palmar muscles on the lateral side of the forearm. This procedure is performed for therapeutic relief of the persistent symptoms of carpal tunnel syndrome.

Coding Tips
For injection of a tendon origin/insertion, see code 20551. Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office.

Terms To Know
carpal tunnel syndrome. Swelling and inflammation in the tendons or bursa surrounding the median nerve caused by repetitive activity. The resulting compression on the nerve causes pain, numbness, and tingling especially to the palm, index, middle finger, and thumb.

ICD-9-CM Diagnostic Codes
354.0 Carpal tunnel syndrome

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")

**Explanation**
The physician injects a therapeutic agent into a single tendon sheath, or ligament, aponeurosis such as the plantar fascia in 20550 and into a single tendon origin/insertion site in 20551. The physician identifies the injection site by palpation or radiographs (reported separately) and marks the injection site. The needle is inserted and the medicine is injected. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent.

**Coding Tips**
Codes 20550 and 20551 should be reported one time only for single or multiple injections to a single tendon sheath, ligament, tendon origin, or tendon insertion. For trigger point injections, see codes 20552-20553. If documentation indicates that the procedure was performed under image guidance (fluoroscopy or CT), see codes 64490-64495. For aspiration or injection of a ganglion cyst, see code 20612. Do not report with 0232T. Report the drug used in the injection with the appropriate HCPCS Level II code when performed in the physician office.

**Terms To Know**
aponeurosis. Flat expansion of white, ribbon-like tendinous tissue that functions as the connection of a muscle to its moving part.
injection. Forcing a liquid substance into a body part such as a joint or muscle.
ligament. Band or sheet of fibrous tissue that connects the articular surfaces of bones or supports visceral organs.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-3,150.7; 100-4,13,80.1; 100-4,13,80.2

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**Explanation**

The physician injects a therapeutic agent into a single or multiple trigger points of one or two muscles in 20552 and into a single or multiple trigger points for three or more muscles in 20553. Trigger points are focal, discrete spots of hypersensitive irritability identified within bands of muscle. These points cause local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers. The physician identifies the trigger point injection site by palpation or radiographic imaging and marks the injection site. The needle is inserted and the medicine is injected into the trigger point. The injection may be done under separately reportable image guidance. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent. The injection procedure is repeated at the other trigger points for multiple sites.

**Coding Tips**

Never use codes 20550-20553 to indicate “dry needling,” see 97810-97814. Injections into tendon sheaths, ligaments, or ganglion cysts are indicated to relieve pain that results from inflammation or other pathological changes in those structures. If imaging guidance is performed, see codes 76942, 77002, and 77021. When documentation indicates that the physician injected a Morton’s neuroma, see code 64455 or 64632. Report the drug used in the injection with the appropriate HCPCS Level II code when performed in the physician office. These codes are reported one time per session, no matter how many injections are provided or muscles injected.

**Terms To Know**

- **ganglion.** Fluid-filled, benign cyst appearing on a tendon sheath or aponeurosis, frequently found in the hand, wrist, or foot and connecting to an underlying joint.
- **injection.** Forcing a liquid substance into a body part such as a joint or muscle.
- **ligament.** Band or sheet of fibrous tissue that connects the articular surfaces of bones or supports visceral organs.
- **trigger point.** Focal, discrete spot of hypersensitivity identified within bands of muscle that causes local or referred pain and may be formed by acute or repetitive trauma to the muscle tissue or too much stress on the fibers.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-3, 150.7
20600-20610

**20600**
Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)

**20605**
intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

**20610**
major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

**Explanation**

After administering a local anesthetic, the physician inserts a needle through the skin and into a joint or bursa. A fluid sample may be removed from the joint or a fluid may be injected for lavage or drug therapy. The needle is withdrawn and pressure is applied to stop any bleeding. Report 20600 for arthrocentesis of a small joint or bursa, such as of the fingers or toes; 20605 for an intermediate joint or bursa, such as the wrist, elbow, ankle, olecranon bursa, or temporomandibular or acromioclavicular area. Report 20610 for a major joint or bursa injection or aspiration, such as of the shoulder, hip, knee joint, or subacromial bursa.

**Coding Tips**

If imaging guidance is performed, see codes 76942, 77002, 77012, and 77021. Code selection depends on the size of the joint. If more than one procedure is performed on the same joint, do not report it separately. Report the drug used in the injection with the appropriate HCPCS Level II code when provided in the physician office.

**Terms To Know**

- **acromioclavicular joint.** Junction between the clavicle and the scapula. The acromion is the projection from the back of the scapula that forms the highest point of the shoulder and connects with the clavicle. Trauma or injury to the acromioclavicular joint is often referred to as a dislocation of the shoulder. This is not correct, however, as a dislocation of the shoulder is a disruption of the glenohumeral joint. **Synonym(s):** AC joint.
- **arthrocentesis.** Puncture and aspiration of fluid from a joint for diagnostic or therapeutic purposes or injection of anesthetics or corticosteroids.
- **aspiration.** Drawing fluid out by suction.
- **bursa.** Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts.
- **injection.** Forcing a liquid substance into a body part such as a joint or muscle.
- **joint.** Area of contact, or juncture, between two or more bones, often articulating with each other.
- **temporomandibular joint.** Joint or hinge formed by the connection of the lower jaw to the temporal bone of the cranium, located in front of the ear on both sides of the face.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
31500

Intubation, endotracheal, emergency procedure

Explanation
The physician places an endotracheal tube to provide air passage in emergency situations. The patient is ventilated with a mask and bag and positioned by extending the neck anteriorly and the head posteriorly. The physician places the laryngoscope into the patient’s mouth and advances the blade toward the epiglottis until the vocal cords are visible. An endotracheal tube is inserted between the vocal cords and advanced to the proper position. The cuff of the endotracheal tube is inflated.

Coding Tips
As exempt from modifier 51, code 31500 has not been designated in the CPT book as an add-on service/procedure. However, codes identified as exempt from modifier 51 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. According to the AMA, emergency endotracheal intubation may be reported separately when performed in connection with critical care. However, it should be noted that some payers may not reimburse separately for this service. See codes 99291 and 99292, and notes for definitions of critical care and other procedures that may be reported.

Terms To Know
anterior. Situated in the front area or toward the belly surface of the body.
epiglottis. Lid-like cartilaginous tissue that covers the entrance to the larynx and blocks food from entering the trachea.
laryngoscopy. Examination of the hypopharynx, larynx, and tongue base with an endoscope.
posterior. Located in the back part or caudal end of the body.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein

Other vein

Explanation
A needle is inserted through the skin to puncture the vein of a child younger than age 3. The needle is inserted into the vein and used for the withdrawal of blood for diagnostic study or for the therapeutic infusion of intravenous medication. A soft flexible catheter may be placed for prolonged therapy. Once the procedure is complete, the needle or catheter is withdrawn and pressure is applied over the puncture site to control bleeding. Use this code for venipuncture when it necessitates the skill of a physician or other qualified health care professional. Do not use this code when routine venipuncture is performed. In 36400 the jugular or femoral vein is punctured. In 36405, the scalp vein is punctured and in 36406, a vein other than the femoral, jugular, or scalp vein is used. The needle is inserted into the vein and used for the withdrawal of blood or for the therapeutic infusion of intravenous medication. A soft flexible catheter may be placed for prolonged therapy. Once the procedure is complete, the needle or catheter is withdrawn and pressure is applied over the puncture site to control bleeding. Use these codes when venipuncture necessitates the skill of a physician or other qualified health care professional. Do not use these codes when routine venipuncture is performed.

Coding Tips
This procedure may be performed by a physician or other qualified health care professional. Check with the specific payer to determine coverage. For a patient 3 years of age or older, see code 36410. For routine venipuncture for collection of specimens, see code 36415. For venipuncture, younger than 3 years of age, scalp or other vein, see codes 36405–36406. This procedure does not include laboratory analysis.

Terms To Know
Catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
Infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.
Jugular vein. Two pairs of veins on either side of the neck that open into the subclavian, sending blood from the head and neck to the heart.
Venipuncture. Piercing a vein through the skin by a needle and syringe or sharp-ended cannula or catheter to draw blood, start an intravenous infusion, instill medication, or inject another substance such as radiopaque dye.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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36410

Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)

**Explanation**

A needle is inserted through the skin to puncture a vein of a person 3 years of age or older. The needle is inserted into the vein and used for the withdrawal of blood for diagnostic study or for the therapeutic infusion of intravenous medication. A soft flexible catheter may be placed for prolonged therapy. Once the procedure is complete, the needle or catheter is withdrawn and pressure is applied over the puncture site to control bleeding. Use this code when the venipuncture necessitates the skills of a physician or other qualified health care professional. Do not use this code when routine venipuncture is performed.

**Coding Tips**

This procedure may be performed by a physician or other qualified health care professional. Check with the specific payer to determine coverage. This procedure does not include laboratory analysis. For venipuncture, younger than 3 years of age, femoral or jugular vein, see code 36400. For venipuncture of a scalp or other vein on a child younger than 3 years of age, see codes 36400–36406. For routine venipuncture for collection of specimens, see codes 36415.

**Terms To Know**
- **catheter**: Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
- **infusion**: Introduction of a therapeutic fluid, other than blood, into the bloodstream.
- **venipuncture**: Piercing a vein through the skin by a needle and syringe or sharp-ended cannula or catheter to draw blood, start an intravenous infusion, instill medication, or inject another substance such as radiopaque dye.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

36450*, 36460*, 36510*, 69990, 96523, 99195*  
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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36555-36556

36555 Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age
36556 age 5 years or older

Explanation
A central venous access device (CVAD) or catheter is one in which the tip terminates in the subclavian, brachiocephalic, or iliac vein; the superior or inferior vena cava; or the right atrium. A centrally inserted CVAD has an entry site in the inferior vena cava or the jugular, subclavian, or femoral vein. For insertion of a non-tunneled, centrally inserted CVAD, the site over the access vein (e.g., subclavian, jugular) is injected with local anesthesia and punctured with a needle. A guidewire is inserted. The central venous catheter is placed over the guidewire. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter is secured into position and dressed. Non-tunneled catheters are percutaneously inserted for short term (five to seven days) use; to infuse medications, fluids, blood products, and parenteral nutrition; and to take blood draws. Report 36555 for insertion for children younger than five years of age and 36556 for a patient five years of age or older.

Coding Tips
Moderate sedation performed with 36555 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

Terms To Know
catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
parentreral nutrition. Nutrients provided subcutaneously, intravenously, intramuscularly, or intradermally for patients during the postoperative period and in other conditions, such as shock, coma, and renal failure.
percutaneous. Through the skin.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
**Explanation**

A central venous access device (CVAD) or catheter is one in which the tip terminates in the subclavian, brachiocephalic, or iliac vein; the superior or inferior vena cava; or the right atrium. A centrally inserted CVAD has an entry site in the inferior vena cava or the jugular, subclavian, or femoral vein. A tunneled catheter has an entrance site at a distance from its entrance into the vascular system; they are "tunneled" through the skin and subcutaneous tissue to a great vein. For insertion of a tunneled, centrally inserted CVAD, without subcutaneous port or pump, standard preparations are made and the site over the access vein (e.g., subclavian, jugular) is injected with local anesthesia and punctured with a needle or accessed by cutdown approach. A guidewire is inserted. A subcutaneous tunnel is created using a blunt pair of forceps or sharp tunneling tools, over the clavicle from the anterior chest wall to the venotomy site, which is dilated to the right size. The catheter is passed through this tunnel over the guidewire and into the target vein. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter is secured into position and any incisions are sutured. Report 36557 for insertion for children younger than five years of age and 36558 for a patient five years of age or older.

**Coding Tips**

Moderate sedation performed with 36557-36558 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 76998.

**Terms To Know**

- **catheter.** Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
- **central venous access device.** Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
- **cutdown.** Small, incised opening in the skin to expose a blood vessel, especially over a vein (venous cutdown) to allow venipuncture and permit a needle or cannula to be inserted for the withdrawal of blood or administration of fluids.
- **fluoroscopy.** Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **guidewire.** Flexible metal instrument designed to lead another instrument in its proper course.
- **subcutaneous.** Below the skin.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**36560-36561**

**36560**  Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age

**36561**  age 5 years or older

**Explanation**

For insertion of a tunneled, centrally inserted CVAD, with subcutaneous port/pump, standard sterile preparations are made and the site over the access vein (e.g., subclavian, jugular) is injected with local anesthesia and punctured with a needle or accessed by cutdown approach. A guidewire is inserted. A subcutaneous tunnel is created using a blunt pair of forceps or sharp tunneling tools, over the clavicle, from the anterior chest wall to the venotomy site, which is dilated to the right size. The catheter is then passed through this tunnel over the guidewire and into the target vein. The subcutaneous pocket for the port/pump is created with an incision through the skin overlying the second rib, a few centimeters from the midline. Blunt dissection and cautery are used to create the pocket in the chest wall and the port/pump is placed. The catheter is connected to the port/pump and checked by injection. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter and port/pump are secured into position and any incisions are sutured. Report 36560 for insertion with a port for children younger than five years of age and 36561 for a patient five years of age or older.

**Coding Tips**

Moderate sedation performed with 36560-36561 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

**Terms To Know**

central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
cutdown. Small, incised opening in the skin to expose a blood vessel, especially over a vein (venous cutdown) to allow venipuncture and permit a needle or cannula to be inserted for the withdrawal of blood or administration of fluids.
dissection. Separating by cutting tissue or body structures apart.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
subcutaneous. Below the skin.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Insertion of tunneled centrally inserted central venous access device with subcutaneous pump

Explanation
For insertion of a tunneled, centrally inserted CVAD, with subcutaneous port/pump, the site over the access vein (e.g., subclavian, jugular) is injected with local anesthesia and punctured with a needle or accessed by cutdown approach. A guidewire is inserted. A subcutaneous tunnel is created using a blunt pair of forceps or sharp tunneling tools, over the clavicle, from the anterior chest wall to the venotomy site, which is dilated to the right size. The catheter is passed through this tunnel over the guidewire and into the target vein. The subcutaneous pocket for the port/pump is created with an incision through the skin overlying the second rib, a few centimeters from the midline. Blunt dissection and cautery are used to create the pocket in the chest wall and the port/pump is placed. The catheter is connected to the port/pump and checked by injection. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter and port/pump are secured into position and any incisions are sutured. Report 36560 for insertion with a port for children younger than five years of age and 36561 for a patient five years of age or older. Report 36563 for insertion with a pump.

Coding Tips
Moderate sedation performed with 36563 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

Terms To Know
- **catheter**: Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
- **central venous access device**: Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
- **fluoroscopy**: Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **guidewire**: Flexible metal instrument designed to lead another instrument in its proper course.
- **local anesthesia**: Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.
- **subcutaneous**: Below the skin.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)

Insertion of tunneled centrally inserted central venous access device, with subcutaneous port(s)

Explanation
For insertion of a tunneled, centrally inserted CVAD, requiring two catheters via two separate venous access sites, without subcutaneous port/pump, the sites of access (e.g., subclavian, jugular vein) for each catheter are injected with local anesthesia and two punctures are made with a needle or cutdown approach. Guidewires are inserted. Two subcutaneous tunnels are created using a blunt pair of forceps or sharp tunneling tools, over the clavicle, from the anterior chest wall to the venotomy sites, which are dilated to the right size. The catheters are each passed through their tunnel, over the guidewires, and into their venotomy sites. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheters are secured into position and any incisions are sutured.

Coding Tips
Moderate sedation performed with 36565-36566 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

Terms To Know
catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
venotomy. Incision or puncture of a vein.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
36568-36569

36568 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
36569 age 5 years or older

Explanation

A central venous access device or catheter is one in which the tip terminates in the subclavian, brachiocephalic, or iliac vein; the superior or inferior vena cava; or the right atrium. A peripherally inserted central venous catheter (PICC) has an entry site in the basilic or cephalic vein in the arm and is threaded into the superior vena cava above the right atrium. PICC lines are used for antibiotic therapy, chemotherapy, total parenteral nutrition, lab work, pain medications, blood transfusions, and hydration the same as a central line. For insertion of a (non-tunneled), peripherally inserted central venous catheter, without subcutaneous port or pump, the access vein (basilic or cephalic) is injected with local anesthesia and punctured with a needle. A guidewire is inserted. The central venous catheter is placed over the guidewire. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter is secured into position, and dressed. Report 36568 for insertion for children younger than five years of age and 36569 for a patient five years of age or older.

Coding Tips

Moderate sedation performed with 36568 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001. For placement of a centrally inserted nontunneled central venous catheter, without a subcutaneous port or pump, see codes 36555 and 36556.

Terms To Know

**blood transfusion.** Introduction of blood or blood products from another source into a vein or artery. *NCD References: 110.7, 110.8.*

**chemotherapy.** Treatment of disease, especially cancerous conditions, using chemical agents.

**fluoroscopy.** Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.

**guidewire.** Flexible metal instrument designed to lead another instrument in its proper course.

**parenteral nutrition.** Nutrients provided subcutaneously, intravenously, intramuscularly, or intradermally for patients during the postoperative period and in other conditions, such as shock, coma, and renal failure.

**PICC.** Peripherally inserted central catheter. PICC is inserted into one of the large veins of the arm and threaded through the vein until the tip sits in a large vein just above the heart.

<table>
<thead>
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<th>Base Unit</th>
<th>Work Value</th>
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ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0


Also not with 36568: 36569#, 99143-99149

Also not with 36569: 99148-99149

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age

age 5 years or older

Explanation
A central venous access device or catheter is one in which the tip terminates in the subclavian, brachiocephalic, or iliac vein; the superior or inferior vena cava; or the right atrium. A peripherally inserted central venous catheter (PICC) has an entry site in the basilic or cephalic vein in the arm and is threaded into the superior vena cava above the right atrium. PICC lines are used for antibiotic therapy, chemotherapy, total parenteral nutrition, lab work, pain medications, blood transfusions, and hydration the same as a central line. For insertion of a peripherally inserted central venous catheter with a subcutaneous port, the site over the access vein (basilic or cephalic) is injected with local anesthesia and punctured with a needle. A guidewire is inserted. The central venous catheter is placed over the guidewire and fed through the vein in the arm into the superior vena cava. The port may be placed in the chest in a subcutaneous pocket created through an incision in the chest wall, or placed in the arm through a small incision just above or halfway between the elbow crease and the shoulder on the inside of the arm. The port is attached to the catheter and checked. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter and port are secured into position and incisions are closed and dressed. Report 36570 for insertion for children younger than five years of age and 36571 for a patient five years of age or older.

Coding Tips
Moderate sedation performed with 36570-36571 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001. For insertion of a tunneled centrally inserted central venous access device, with a subcutaneous port, see codes 36560 and 36561.

Terms To Know
- **blood transfusion**: Introduction of blood or blood products from another source into a vein or artery. NCD References: 110.7, 110.8.
- **chemotherapy**: Treatment of disease, especially cancerous conditions, using chemical agents.
- **fluoroscopy**: Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **parenteral nutrition**: Nutrients provided subcutaneously, intravenously, intramuscularly, or intradurally for patients during the postoperative period and in other conditions, such as shock, coma, and renal failure.

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CCI Version 20.0
Also not with 36570: 36571*

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**36575-36576**

**36575** Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site

**36576** Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

**Explanation**

This code reports repair of a central venous access device (CVAD) that has external catheters with the access ports outside the body, and no subcutaneous ports or pumps, whether centrally or peripherally inserted, tunneled or non-tunneled. The repair is done on the catheter that is placed without any replacement of components. A Hickman catheter is an example of a tunneled CVAD with an external port.

**Coding Tips**

Moderate sedation performed with 36576 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used for obtaining access to the venous access site or for manipulating the catheter into final end position, see 76937 or 77001. Partial replacement of a central venous access device (catheter only) with subcutaneous port or pump, central or peripheral, is reported with 36578. Mechanical removal of pericatheter obstructive material is reported with code 36595; intracatheter obstructive material, see 36596.

**Terms To Know**

**central venous access device.** Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.

**Hickman catheter.** Central venous catheter used for long-term delivery of medications, such as antibiotics, nutritional substances, or chemotherapeutic agents.

**peripherally inserted central venous catheter.** Catheter that originates in the basilic or cephalic vein in the arm and is threaded into the superior vena cava above the right atrium.

**subcutaneous.** Below the skin.

**ICD-9-CM Diagnostic Codes**

996.1 Mechanical complication of other vascular device, implant, and graft

999.31 Other and unspecified infection due to central venous catheter

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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<th>Base Unit</th>
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</table>
Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

**Explanation**
The catheter only of a central venous access device with a subcutaneous port or pump is replaced, whether centrally or peripherally inserted. Local anesthesia is given and the subcutaneous pocket over the port is incised. The catheter is disconnected. A guidewire is placed through the existing catheter, which is removed over the guidewire. A new central venous catheter of correct length is placed into position and connected to the port/pump device that has not been removed or replaced. The connection with the new catheter is checked, as well as the catheter and port secured, and the wound is dressed.

**Coding Tips**
Moderate sedation performed with 36578 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. For the complete replacement of an entire device through the same venous access, see code 36582 or 36583. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

**Terms To Know**
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
moderate sedation. Medically controlled state of depressed consciousness, with or without analgesia, while maintaining the patient’s airway, protective reflexes, and ability to respond to stimulation or verbal commands.
subcutaneous. Below the skin.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<td>Mechanical complication of other vascular device, implant, and graft</td>
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<tr>
<td>996.62</td>
<td>Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)</td>
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<td>999.31</td>
<td>Other and unspecified infection due to central venous catheter</td>
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<tr>
<td>999.32</td>
<td>Bloodstream infection due to central venous catheter</td>
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<tr>
<td>999.33</td>
<td>Local infection due to central venous catheter</td>
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<tr>
<td>V58.81</td>
<td>Fitting and adjustment of vascular catheter</td>
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</tbody>
</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<th>Procedure Codes</th>
<th>Coding and Payment Guide for Anesthesia Services</th>
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</thead>
<tbody>
<tr>
<td>36578</td>
<td>Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site</td>
</tr>
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</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Terms To Know**
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
moderate sedation. Medically controlled state of depressed consciousness, with or without analgesia, while maintaining the patient’s airway, protective reflexes, and ability to respond to stimulation or verbal commands.
subcutaneous. Below the skin.

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnostic Codes</th>
<th>Base Unit</th>
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Explanation

In 36580, a non-tunneled, centrally inserted central venous catheter, without subcutaneous port or pump, is replaced through the same venous access site. Local anesthesia is given. A guidewire is first passed through the existing central line catheter and then the catheter is placed back into position over the guidewire, secured into position, and dressed. In 36581, a tunneled, centrally inserted central venous catheter, without subcutaneous port or pump is replaced. Local anesthesia is given and the sutures securing the cuff of the indwelling catheter are freed from the skin. A guidewire is next placed through the existing catheter, which is then removed, and a new central venous catheter is inserted into the tunneled position over the guidewire. The new catheter is secured into position and the wound is dressed.

Coding Tips

Moderate sedation performed with 36581 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

Terms To Know

catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
moderate sedation. Medically controlled state of depressed consciousness, with or without analgesia, while maintaining the patient’s airway, protective reflexes, and ability to respond to stimulation or verbal commands.
replacement. Insertion of new tissue or material in place of old one.

ICD-9-CM Diagnostic Codes

996.74 Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)
999.31 Other and unspecified infection due to central venous catheter
999.32 Bloodstream infection due to central venous catheter
999.33 Local infection due to central venous catheter
V58.81 Fitting and adjustment of vascular catheter

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0


Also not with 36580: 99148-99149
Also not with 36581: 99143-99149

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
36582-36583

36582 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access

36583 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access

Explanation
A tunneled, centrally inserted central venous catheter, along with a subcutaneous port (36582) or pump (36583) device is replaced. Local anesthesia is given and the subcutaneous pocket over the port/pump device is incised. The pump/port is dissected free and tested. The catheter is disconnected and the pump/port device is removed from its pocket. A guidewire is placed over the existing catheter, which is removed, and a new central venous catheter is threaded into position over the guidewire. A new pump/port device is inserted into the subcutaneous pocket and the catheter is connected. The connection is checked with an injection. The new pump/port is secured into the pocket, incisions are closed, and the wound is dressed.

Coding Tips
Moderate sedation performed with 36582 and 36583 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

Terms To Know
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
injection. Forcing a liquid substance into a body part such as a joint or muscle.
replacement. Insertion of new tissue or material in place of old one.
subcutaneous. Below the skin.

ICD-9-CM Diagnostic Codes
996.1 Mechanical complication of other vascular device, implant, and graft
996.62 Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)
996.74 Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)
999.31 Other and unspecified infection due to central venous catheter
V53.90 Fitting and adjustment of other and unspecified device, Unspecified device
V53.99 Fitting and adjustment, Other device

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<th>Base Unit</th>
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Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access

Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access

Explanation
A peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, is replaced through the same venous access site in 36584. Local anesthesia is given and the sutures securing the cuff of the catheter with external port are freed from the skin and it is partially withdrawn. A sheath is placed over the nonfunctioning catheter and it is completely withdrawn. A guidewire is inserted into the access site through the sheath and advanced. A new catheter of correct length is placed over the guidewire and the sheath and guidewire are removed. The catheter is fastened in position and the wound is dressed.

A peripherally inserted central venous access device, with subcutaneous port, is replaced through the same venous access site in 36585. Local anesthesia is given, the skin over the subcutaneous pocket is incised, and the port is dissected free. A sheath is placed over the nonfunctioning catheter and it is completely withdrawn. A guidewire is inserted into the access site through the sheath and advanced. A new catheter of correct length is placed over the guidewire and the sheath and guidewire are removed. The catheter is fastened in position and the wound is dressed.

Coding Tips
Moderate sedation performed with 36585 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001.

Terms To Know
- **guidewire**: Flexible metal instrument designed to lead another instrument in its proper course.
- **moderate sedation**: Medically controlled state of depressed consciousness, with or without analgesia, while maintaining the patient's airway, protective reflexes, and ability to respond to stimulation or verbal commands.
- **PICC**: Peripherally inserted central catheter. PICC is inserted into one of the large veins of the arm and threaded through the vein until the tip sits in a large vein just above the heart.
- **replacement**: Insertion of new tissue or material in place of old one.
- **sheath**: Covering enclosing an organ or part.

ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<td>Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)</td>
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<td>Other and unspecified infection due to central venous catheter</td>
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<td>Fitting and adjustment of other and unspecified device, Unspecified device</td>
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<td>V53.99</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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<table>
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<tr>
<th>Code</th>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
36589-36590
36589 Removal of tunneled central venous catheter, without subcutaneous port or pump
36590 Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion

Explanation
In 36589, a tunneled central venous catheter without subcutaneous port or pump is removed. Local anesthesia is given and the sutures securing the cuff of the tunneled catheter's external port are freed from the skin. A guidewire is next placed through the catheter, which is withdrawn over the guidewire. After the guidewire is removed, the wound is dressed. In 36590, a tunneled central venous access device, both catheter and subcutaneous port or pump, is removed. Local anesthesia is given and the subcutaneous pocket over the port/pump device is incised and the pump/port is dissected free. The catheter is disconnected and the pump/port device is removed from its pocket. A guidewire is placed over the existing catheter, which is withdrawn over the guidewire, and the guidewire is removed. The incisions are closed and the wound is dressed.

Coding Tips
Do not report code 36589 for removal of nontunneled central venous catheters. Moderate sedation performed with 36590 is considered to be an integral part of the procedure and is not reported separately. However, anesthesia services (00100-01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure. Do not report 36590 for removal of nontunneled central venous catheters. If imaging guidance is used, either for obtaining access to the venous access site or for manipulating the catheter into its final end position, see codes 76937 and 77001. When a central venous access device is removed and a new one inserted at a separate venous access site, the codes for the removal of the old device and the insertion of the new one should both be reported.

Terms To Know
central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.
moderate sedation. Medically controlled state of depressed consciousness, with or without analgesia, while maintaining the patient’s airway, protective reflexes, and ability to respond to stimulation or verbal commands.
removal. Process of moving out of or away from, or the fact of being removed.

ICD-9-CM Diagnostic Codes
996.1 Mechanical complication of other vascular device, implant, and graft
996.62 Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)
996.74 Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)
999.31 Other and unspecified infection due to central venous catheter

CCI Version 20.0
Also not with 36589: 99148-99149
Also not with 36590: 36589, 99143-99149, J0670, J2001

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Collecting Blood Specimen from a Completely Implantable Venous Access Device

**Explanation**

The physician obtains a blood specimen from a previously placed, completely implantable venous access device. Completely implanted devices are those that have access through a subcutaneous port (e.g., Port-A-Cath, Infusaport). An implantable access device requires a percutaneous noncoring needle to accomplish the blood draw. The skin is cleansed with alcohol or iodine solution. The needle is placed into the port. Heparin is withdrawn. A second needle is inserted and the blood specimen obtained. The port is flushed with heparin solution.

**Coding Tips**

This service may only be reported in addition to laboratory services. To report collection of venous blood by venipuncture, see code 36415. To report collection of capillary blood, see code 36416.

**Terms To Know**

- **Implantable venous access device.** Catheter implanted for continuous access to the venous system for long-term parenteral feeding or for the administration of fluids or medications.
- **Percutaneous.** Through the skin.
- **Port-a-cath.** Brand name for an implantable system used for vascular access when the patient’s treatment plan requires repeat administration of drugs (e.g., chemotherapy), fluids, and/or nutrition. This system may also be used for repeated blood sampling.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

No CCI Edits apply to this code.

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36592

36592  Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified

Explanation
The physician obtains a blood specimen from an established central venous or peripheral venous catheter. A central venous catheter (CVC) is one that is inserted through the skin into central veins, such as the femoral, internal jugular, or subclavian veins. Peripheral catheters include those inserted in the arm veins (basilic or cephalic), such as a PICC line, saline lock, or heparin lock. In order to clear the catheter of any material that could contaminate the sample and affect the test results, a specific volume of infusing fluid and blood must be discarded before a blood specimen is obtained; this volume will vary depending on the type of catheter utilized. With a central venous catheter, a three-way stopcock is attached to the catheter’s hub and two syringes attached to the stopcock. Using one syringe, the catheter is flushed with normal saline. A specific amount of blood is aspirated into the same syringe used for the saline flush and discarded. The blood sample is then withdrawn using the other syringe and placed into an appropriate tube for laboratory analysis. If using a peripheral venous catheter, a specific amount of blood is also aspirated and discarded before the blood sample is drawn.

Coding Tips
This service may only be reported in addition to laboratory services. To report blood collection from an established arterial catheter, see code 37799.

Terms To Know

catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

specimen. Tissue cells or sample of fluid taken for analysis, pathologic examination, and diagnosis.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
No CCI Edits apply to this code.

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36595

Explanation
Pericatheter obstructive material such as a fibrin sheath is removed from around a central venous device via separate venous access. Central venous catheters often fail because of the accumulation of an obstructing thrombus or fibrin sheath around the tip of the catheter. The catheter is first checked that it can aspirate and flush forward. The pericatheter material is identified by contrast material injection. Generally, a right femoral vein access is used. A guidewire followed by an angiographic catheter are advanced into the superior vena cava and exchanged for a loop snare with its catheter, which are advanced cephalad along the length of the central venous catheter beyond the ports. The loop snare is tightly closed about the central venous catheter to encircle it and slowly pulled down and off the tip of the catheter, stripping off the pericatheter obstructive material. This is repeated a few times and the catheter is rechecked for infusion and injection ability of the ports. A contrast study is done again to identify any fibrin and the process may be repeated until the fibrin sheath is completely removed.

Coding Tips
Do not report code 36595 with 36593. For venous catheterization, see codes 36010-36012. For radiological supervision and interpretation, see code 75901.

Terms To Know
cephalad. Toward the head.
fibrin sheath. Obstructive material or thrombus that forms around or within the lumen of an indwelling catheter or central venous access device.
thrombus. Stationary blood clot inside a blood vessel.

ICD-9-CM Diagnostic Codes
996.1 Mechanical complication of other vascular device, implant, and graft
996.62 Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)
996.74 Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.
Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen

Explanation
In 36595, pericatheter obstructive material such as a fibrin sheath is removed from around a central venous device via a separate venous access. Central venous catheters often fail because of the accumulation of an obstructing thrombus or fibrin sheath around the tip of the catheter. The catheter is first checked that it can aspirate and flush forward. The pericatheter material is identified by contrast material injection. Generally, a right femoral vein access is used. A guidewire followed by an angiographic catheter are advanced into the superior vena cavae and exchanged for a loop snare with its catheter, which are advanced cephalad along the length of the central venous catheter beyond the ports. The loop snare is then tightly closed about the central venous catheter to encircle it and slowly pulled down and off the tip of the catheter, stripping off the pericatheter obstructive material. This is repeated a few times and the catheter is rechecked for infusion and injection ability of the ports. A contrast study is done again to identify any fibrin and the process may be repeated until the fibrin sheath is completely removed. In 36596, intraluminal obstructive material, such as a thrombus or fibrin sheath, is removed from inside a central venous device through the lumen of the device. This does not require a separate access incision. The central venous catheter is first checked that it can aspirate and flush forward. The obstructing material is disrupted and removed mechanically by using an angioplasty balloon or other catheter introduced into the central venous catheter through its entry site on the skin. The catheter is checked for unimpeded, restored flow and the process may be repeated until the central venous catheter is cleared.

Coding Tips
Do not report code 36596 with 36593. For venous catheterization, see codes 36010-36012. For radiological supervision and interpretation, see code 75902.

Terms To Know
- **angioplasty balloon.** Balloon-tipped medical device used to clear the blockage of an artery. After insertion into the clogged artery, the balloon is inflated to expand a narrowing arterial section.
- **fibrin sheath.** Obstructive material or thrombus that forms around or within the lumen of an indwelling catheter or central venous access device.
- **thrombus.** Stationary blood clot inside a blood vessel.

ICD-9-CM Diagnostic Codes

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<th>Code</th>
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<td>Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)</td>
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<th>Code</th>
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<tr>
<td>996.74</td>
<td>Other complications due to other vascular device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Repositioning of previously placed central venous catheter under fluoroscopic guidance

Explanation
A previously placed central venous catheter needs to be repositioned. It is possible for a catheter position to change significantly after the procedure is completed. Catheter position change and tip migration occur most often with subclavian venous access in women and obese patients, because the soft tissues of the chest wall move inferiorly with standing and often cause the catheter to get pulled back. When a catheter tip is incorrectly placed, it can increase the risks of thrombosis, fibrin sheath formation, perforation of the vein, and even arrhythmias. Fluoroscopy is used to check the positioning of the catheter tip and guide it to its correct position. Local anesthesia is given, and the sutures securing the cuff of the catheter may be freed from the skin. The catheter is partially withdrawn, and a sheath may be placed over the catheter at the existing venous access site. A guidewire is inserted through the catheter and advanced. The central venous catheter is maneuvered back into correct position and monitored with fluoroscopy to view correct placement of the tip.

Coding Tips
For fluoroscopic guidance, see code 76000. When a central venous access device is removed and a new one is inserted at a separate venous access site, the codes for the removal of the old device and insertion of the new one should both be reported.

Terms To Know
- arrhythmia. Irregular heartbeat.
- fibrin sheath. Obstructive material or thrombus that forms around or within the lumen of an indwelling catheter or central venous access device.
- fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- reposition. Placement of an organ or structure into another position or return of an organ or structure to its original position.
- thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

Explanation
The physician accesses, in most cases, the ulnar or radial artery to insert a cannula, or tube-shaped portal. In 36620, the physician inserts a needle through the skin to puncture the artery and inserts a cannula. In 36625, the physician makes an incision in the skin overlying the artery and dissects the surrounding tissue to access it. The artery is sometimes nicked with a thin-bladed scalpel before the physician inserts the cannula. This cannula acts as a portal for sampling, monitoring or transfusion. Once the procedure is complete, the cannula is removed. In an open procedure, the opening in the artery may be sutured and the incision repaired with a layered closure. Pressure is applied to the puncture if a percutaneous approach is used.

Coding Tips
These separate procedures by definition are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services they may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59. As “exempt from modifier S1,” 36620 has not been designated in CPT as an add-on service/procedure. However, codes identified as exempt from modifier S1 are not subject to multiple procedure rules. No reimbursement reduction or modifier S1 is applied. These codes include only the insertion of the tube for giving the transfusion. These codes are considered standard anesthesia monitoring services and should not be billed in conjunction with an anesthesia service code.

Terms To Know
arterial catheterization. Introduction of a narrow, hollow tube within an artery to allow for therapeutic or diagnostic proceedings, such as visualization inside the lumen, measurement of arterial pressures, injections, or repair.
cannulation. Insertion of a flexible length of hollow tubing into a blood vessel, duct, or body cavity, usually for extracorporeal circulation or chemotherapy infusion to a particular region of the body.
cutdown. Small, incised opening in the skin to expose a blood vessel, especially over a vein (venous cutdown) to allow venipuncture and permit a needle or cannula to be inserted for the withdrawal of blood or administration of fluids.
monitoring. Recording of events; keep track, regulate, or control patient activities and record findings.
percutaneous. Through the skin.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days.

### Explanation
Epidural adhesions are lysed percutaneously by an injection, such as hypertonic saline or an enzyme solution, or by mechanical means. The patient is placed in the sitting or lateral decubitus position for insertion of a needle into a vertebral interspace. The site to be entered is sterilized, local anesthesia is administered, and the needle is inserted. Separately reportable contrast media with fluoroscopy may be injected to confirm proper needle placement and to identify epidural adhesions. The physician injects the adhesiolytic solution or performs mechanical adhesion destruction, such as with a catheter, to lyse epidural adhesions. The needle and/or catheter is removed and the wound is dressed. Report 62263 for multiple adhesiolysis sessions on two or more days and 62264 for multiple adhesiolysis sessions occurring only on one day.

### Coding Tips
Code 62263 should be reported once for the entire series of injections/infusions spanning two or more treatment days. Code 62284 describes multiple adhesiolysis treatment sessions performed on the same day. Codes 62263 and 62264 include contrast injection for epidurography (72275) and fluoroscopic guidance and localization (77003). Do not report code 62264 with 62263. For endoscopic lysis of adhesions, see code 64999.

### Terms To Know
- **fluoroscopy.** Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **lysis of adhesions.** Mobilization or release of an organ by dividing and freeing restricting adhesions.
- **vertebral interspace.** Non-bony space between two adjacent vertebral bodies that contains the cushioning intervertebral disk.

### ICD-9-CM Diagnostic Codes
- **349.2** Disorders of meninges, not elsewhere classified
- **742.59** Other specified congenital anomaly of spinal cord

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Spinal puncture, lumbar, diagnostic

Explanation

The patient is placed in a spinal tap position. The biopsy needle is inserted. Fluid is drawn through the needle for separately reportable testing. When the procedure is completed, the needle is removed and the wound is dressed.

Coding Tips

Injection of contrast is included in code 62270 and should not be reported separately. For fluoroscopic guidance and localization, see code 77003.

Terms To Know

Contrast material. Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomograph; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.

Fluoro. Fluoroscopy.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
### 62273
Injection, epidural, of blood or clot patch

**Explanation**
This procedure is performed following a spinal puncture to prevent spinal fluid leakage. The patient remains in a spinal tap position. The patient's blood is injected outside the dura to clot and plug the wound, preventing spinal fluid leakage. The wound is dressed and monitored.

**Coding Tips**
This procedure is sometimes performed after delivery when epidural anesthesia was used. This procedure is often used to treat headache caused by leakage of spinal fluid. Injection of contrast is included in code 62273 and should not be reported separately. For fluoroscopic guidance and localization, see code 77003. For injection of diagnostic or therapeutic substance(s), see codes 62310, 62311, 62318, and 62319. This code is not limited to the lumbar region.

**Terms To Know**
- **fluoroscopy**: Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **injection**: Forcing a liquid substance into a body part such as a joint or muscle.

**ICD-9-CM Diagnostic Codes**
- 349.0 Reaction to spinal or lumbar puncture
- 784.0 Headache
- 997.09 Other nervous system complications — (Use additional code to identify complications)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**IOM References**
100-3,10.5

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CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid

Explanation
This procedure is performed to destroy nerve tissue or adhesions. The patient is placed in a spinal tap position. The site is sterilized, and the needle is inserted under fluoroscopic guidance. Once the injection/infusion is completed, the needle is removed and the wound dressed. Report 62280 if the substance is administered to the subarachnoid level. Report 62281 if the needle is inserted in the epidural region of a cervical or thoracic level. Report 62282 if the needle is inserted in the epidural region of a lumbar or sacral (caudal) level.

Coding Tips
As with all neurolytic injections, correct code assignment is dependent upon the type of injection. For this reason, the exact level and space of the injection should be verified in the medical record documentation. Injection of contrast is included and should not be reported separately. For fluoroscopic guidance and localization, see code 77003.

Terms To Know
adhesion. Abnormal fibrous connection between two structures, soft tissue or bony structures, that may occur as the result of surgery, infection, or trauma.
dura mater. Outermost, hard, fibrous layer or membrane that surrounds the brain and spinal cord.
subarachnoid. Located below the arachnoid meningeal layer.

ICD-9-CM Diagnostic Codes

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<td>Spasmodic torticollis — (Use additional E code to identify drug, if drug-induced)</td>
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<tr>
<td>337.22</td>
<td>Reflex sympathetic dystrophy of the lower limb</td>
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<td>337.9</td>
<td>Unspecified disorder of autonomic nervous system</td>
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<td>340</td>
<td>Multiple sclerosis</td>
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<td>353.1</td>
<td>Lumbosacral plexus lesions</td>
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<td>353.4</td>
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<td>Causalgia of upper limb</td>
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<td>Mononeuritis multiplex</td>
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<td>355.71</td>
<td>Causalgia of lower limb</td>
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<tr>
<td>715.98</td>
<td>Osteoarthrosis, unspecified whether generalized or localized, other specified sites</td>
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<tr>
<td>722.52</td>
<td>Degeneration of lumbar or lumbosacral intervertebral disc</td>
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<tr>
<td>722.83</td>
<td>Postlaminectomy syndrome, lumbar region</td>
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<tr>
<td>724.02</td>
<td>Spinal stenosis of lumbar region, without neurogenic claudication</td>
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<td>724.2</td>
<td>Lumbago</td>
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<td>729.2</td>
<td>Unspecified neuralgia, neuritis, and radiculitis</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Also not with 62280: 0213T, 0216T, 62284, 62310-62319, 64490, 64493
Also not with 62281: 0213T, 62284, 62310-62318, 64490, 72275, J2001
Also not with 62282: 0216T, 62310-62311, 62319, 64493, 72275, J2001
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
ICD-9-CM Diagnostic Codes

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</tr>
<tr>
<td>62311</td>
<td>lumbar or sacral (caudal)</td>
</tr>
</tbody>
</table>

**Explanation**

The patient is placed in a sitting or lateral decubitus position for the physician to insert a needle into the vertebral interspace of the thoracic or cervical region. The site to be entered is sterilized, local anesthesia is administered and the needle is inserted. Contrast media with fluoroscopy may be injected to confirm proper needle placement. The physician injects a solution to provide a therapeutic or diagnostic outcome. The solution is injected into the epidural or subarachnoid space. With the procedure complete the needle is removed and the wound is closed.

**Coding Tips**

Injection of contrast is included and should not be reported separately. Placement and use of a catheter to administer one or more epidural or subarachnoid injections on a single date of service should be reported in the same way as if a needle had been used (62310–62311). If the catheter is left in place to deliver substances over a prolonged period, such as more than one calendar day, see 62318–62319. For fluoroscopy guidance and localization, see 77003. For radiological supervision and interpretation of epidurography, see 72275. Report 72275 only when an epidurogram is performed and recorded, and a written radiological interpretation is provided. To report transforaminal epidural injection, see 64479–64484.

**Terms To Know**

- **contrast material.** Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomography; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.
- **decubitus.** Patient lying on the side.
- **fluoroscopy.** Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **subarachnoid.** Located below the arachnoid meningeal layer.
- **vertebral interspace.** Non-bony space between two adjacent vertebral bodies that contains the cushioning intervertebral disk.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>721.0</td>
<td>Cervical spondylosis without myelopathy</td>
</tr>
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<td>721.1</td>
<td>Cervical spondylosis with myelopathy</td>
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<tr>
<td>721.2</td>
<td>Thoracic spondylosis without myelopathy</td>
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<tr>
<td>721.41</td>
<td>Spondylosis with myelopathy, thoracic region</td>
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<tr>
<td>722.0</td>
<td>Displacement of cervical intervertebral disc without myelopathy</td>
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<tr>
<td>722.11</td>
<td>Displacement of thoracic intervertebral disc without myelopathy</td>
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<tr>
<td>722.31</td>
<td>Schmorl's nodes, thoracic region</td>
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<tr>
<td>722.4</td>
<td>Degeneration of cervical intervertebral disc</td>
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<td>722.51</td>
<td>Degeneration of thoracic or thoracolumbar intervertebral disc</td>
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<td>Postlaminectomy syndrome, cervical region</td>
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<td>722.82</td>
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<td>722.92</td>
<td>Other and unspecified disc disorder of thoracic region</td>
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<td>723.0</td>
<td>Spinal stenosis in cervical region</td>
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<tr>
<td>723.1</td>
<td>Cervicalgia</td>
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<tr>
<td>723.2</td>
<td>Cervicocranial syndrome</td>
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<tr>
<td>723.3</td>
<td>Cervicobrachial syndrome (diffuse)</td>
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<td>723.4</td>
<td>Brachial neuritis or radiculitis NOS</td>
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<td>723.8</td>
<td>Other syndromes affecting cervical region</td>
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<td>724.01</td>
<td>Spinal stenosis of thoracic region</td>
</tr>
<tr>
<td>724.4</td>
<td>Thoracic or lumbosacral neuritis or radiculitis, unspecified</td>
</tr>
<tr>
<td>733.20</td>
<td>Unspecified cyst of bone (localized)</td>
</tr>
<tr>
<td>847.0</td>
<td>Neck sprain and strain</td>
</tr>
<tr>
<td>847.1</td>
<td>Thoracic sprain and strain</td>
</tr>
</tbody>
</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**


Also not with 62310: 0228T, 644790
Also not with 62311: 0230T, 644830

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
<thead>
<tr>
<th>Base Unit</th>
<th>Work Value</th>
<th>Non-Fac PE</th>
<th>Fac PE</th>
<th>Malpractice</th>
<th>Non-Fac Total</th>
<th>Fac Total</th>
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<td>0.77</td>
<td>0.09</td>
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</tr>
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</table>
Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic lumbar or sacral (caudal)

**Explanation**

The patient is placed in the sitting or lateral decubitus position for the physician to insert a catheter into the vertebral interspace of the cervical or thoracic region for continuous or intermittent infusion of material. The site to be entered is sterilized, local anesthesia is administered and the infusion catheter is inserted. Contrast media with fluoroscopy may be injected to confirm proper catheter placement. The physician provides continuous infusion or intermittent bolus injection of solution to provide a therapeutic or diagnostic outcome. The solution is injected into the epidural or subarachnoid space. With the procedure complete the needle is removed and the wound is dressed.

**Coding Tips**

Injection of contrast is included and should not be reported separately. For fluoroscopic guidance and localization, see code 77003. Placement and use of a catheter to administer one or more epidural or subarachnoid injections on a single date of service should be reported in the same way as if a needle had been used (62310–62311), as opposed to the infusion/intermittent bolus described by 62318–62319. For radiological supervision and interpretation of epidurography, see code 72275. Report code 72275 only when an epidurogram is performed and recorded, and a written radiological report is provided. To report transforaminal epidural injection, see codes 64479–64484. The daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with codes 62318 and 62319 should be reported with code 01996.

**ICD-9-CM Diagnostic Codes**

- Multiple sclerosis (340)
- Cervical spondylosis without myelopathy (721.0)
- Cervical spondylosis with myelopathy (721.1)
- Thoracic spondylosis without myelopathy (721.2)
- Spondylosis with myelopathy, thoracic region (721.41)
- Displacement of cervical intervertebral disc without myelopathy (722.0)
- Displacement of thoracic intervertebral disc without myelopathy (722.11)
- Schmorl's nodes, thoracic region (722.31)
- Degeneration of cervical intervertebral disc (722.4)
- Degeneration of thoracic or thoracolumbar intervertebral disc (722.51)
- Intervertebral cervical disc disorder with myelopathy, cervical region (722.71)
- Intervertebral thoracic disc disorder with myelopathy, thoracic region (722.72)
- Postlaminectomy syndrome, cervical region (722.81)
- Postlaminectomy syndrome, thoracic region (722.82)
- Other and unspecified disc disorder of cervical region (722.91)
- Other and unspecified disc disorder of thoracic region (722.92)
- Spinal stenosis in cervical region (723.0)
- Cervicalgia (723.1)
- Cervicocranial syndrome (723.2)
- Cervicobrachial syndrome (diffuse) (723.3)
- Brachial neuritis or radiculitis NOS (723.4)
- Other syndromes affecting cervical region (723.8)
- Thoracic neuritis or radiculitis (724.4)
- Thoracic or lumbosacral neuritis or radiculitis, unspecified (733.20)
- Unspecified cyst of bone (localized) (733.21)
- Solitary bone cyst (733.22)
- Neck sprain and strain (847.0)
- Thoracic sprain and strain (847.1)

**Note:** These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
ICD-9-CM Diagnostic Codes

Located below the arachnoid meningeal layer.

Subarachnoid reservoir. Space or body cavity for storage of liquid.

Cerebrospinal fluid. Thin, clear fluid circulating in the cranial cavity and spinal column that bathes the brain and spinal cord.

Infusion pump. Device that delivers a measured amount of drug or intravenous solution through injection over a period of time.

Reservoir. Space or body cavity for storage of liquid.

Subarachnoid. Located below the arachnoid meningeal layer.

**ICD-9-CM Diagnostic Codes**

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>191.7</td>
<td>Malignant neoplasm of brain stem</td>
</tr>
<tr>
<td>192.2</td>
<td>Malignant neoplasm of spinal cord</td>
</tr>
<tr>
<td>192.3</td>
<td>Malignant neoplasm of spinal meninges</td>
</tr>
<tr>
<td>198.3</td>
<td>Secondary malignant neoplasm of brain and spinal cord</td>
</tr>
</tbody>
</table>

**62350-62351**

**62350** Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy

**62351** with laminectomy

**Explanation**

This procedure is performed to allow direct instillation of medication via cerebrospinal fluid. If the catheter is to be implanted the patient is placed in a spinal tap position and the fascia, paravertebral muscles, and ligaments are incised and separated. The physician inserts the catheter tip into the epidural space (the space outside the dura) or through the dura placing the catheter tip into the subarachnoid space. Tissue around the catheter may be sutured to hold the catheter in place. The catheter end is tunneled to the site where an implantable reservoir or implantable infusion pump has been previously placed or where a pump or reservoir is to be placed (subcutaneously) in a separately reportable procedure. This procedure also includes the revision of an intrathecal or epidural catheter, which may include replacing or repositioning a catheter. In 62351, the physician performs a laminectomy, making an incision and removing the lamina of the vertebra to access the dura through which the catheter is inserted. In 62355, the catheter is removed.

**Coding Tips**

Two codes are required for reporting implantation of spinal drug infusion devices. Codes 62350-62355 report procedures related to implantation, revision, repositioning, or removal of the catheter only.

For implantation or replacement of the reservoir or pump, see codes 62360-62362; for removal, see code 62365. When code 62350, 62351, or 62355 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For percutaneous placement of an intrathecal or epidural catheter, see codes 62270-62273, 62280-62284, and 63210-62319. For refilling or maintenance of an implantable reservoir/infusion pump, see code 96522.

**Terms To Know**

cerebrospinal fluid. Thin, clear fluid circulating in the cranial cavity and spinal column that bathes the brain and spinal cord.

infusion pump. Device that delivers a measured amount of drug or intravenous solution through injection over a period of time.

reservoir. Space or body cavity for storage of liquid.

subarachnoid. Located below the arachnoid meningeal layer.

**CCI Version 20.0**


**Coding and Payment Guide for Anesthesia Services**

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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</thead>
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<tr>
<td>199.0</td>
<td>Disseminated malignant neoplasm</td>
</tr>
<tr>
<td>199.1</td>
<td>Other malignant neoplasm of unspecified site</td>
</tr>
<tr>
<td>202.80</td>
<td>Other malignant lymphomas, unspecified site, extranodal and solid organ sites</td>
</tr>
<tr>
<td>202.90</td>
<td>Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites</td>
</tr>
<tr>
<td>722.81</td>
<td>Postlaminectomy syndrome, cervical region</td>
</tr>
<tr>
<td>722.82</td>
<td>Postlaminectomy syndrome, thoracic region</td>
</tr>
<tr>
<td>722.83</td>
<td>Postlaminectomy syndrome, lumbar region</td>
</tr>
<tr>
<td>723.1</td>
<td>Cervicalgia</td>
</tr>
<tr>
<td>724.1</td>
<td>Pain in thoracic spine</td>
</tr>
<tr>
<td>724.2</td>
<td>Lumbago</td>
</tr>
<tr>
<td>996.2</td>
<td>Mechanical complication of nervous system device, implant, and graft</td>
</tr>
<tr>
<td>996.63</td>
<td>Infection and inflammatory reaction due to nervous system device, implant, and graft — (Use additional code to identify specified infections)</td>
</tr>
<tr>
<td>996.75</td>
<td>Other complications due to nervous system device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)</td>
</tr>
<tr>
<td>V53.09</td>
<td>Fitting and adjustment of other devices related to nervous system and special senses</td>
</tr>
</tbody>
</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.
Explanation
This procedure is performed to allow direct instillation of medication via the cerebrospinal fluid. If the catheter is to be implanted, the patient is placed in a spinal tap position and the fascia, paravertebral muscles, and ligaments are incised and separated. The physician inserts the catheter tip into the epidural space (the space outside the dura) or through the dura placing the catheter tip into the subarachnoid space. Tissue around the catheter may be sutured to hold the catheter in place. The catheter end is tunneled to the site where an implantable reservoir or implantable infusion pump has been previously placed or where a pump or reservoir is to be placed (subcutaneously) in a separately reportable procedure. This procedure also includes the revision of an intrathecal or epidural catheter, which may include replacing or repositioning a catheter. In 62351, the physician performs a laminectomy, making an incision and removing the lamina of the vertebra to access the dura through which the catheter is inserted. In 62355, the catheter is removed.

Coding Tips
Two codes are required for reporting implantation of spinal drug infusion devices. Codes 62350-62355 report procedures related to implantation, revision, repositioning, or removal of the catheter only. For implantation or replacement of the reservoir or pump, see codes 62360-62362; for removal, see code 62365. When code 62350, 62351, or 62355 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For percutaneous placement of an intrathecal or epidural catheter, see codes 62270-62273, 62280-62284, and 62310-62319. For refilling or maintenance of an implantable reservoir/infusion pump, see code 96322.

ICD-9-CM Diagnostic Codes
191.7 Malignant neoplasm of brain stem
192.2 Malignant neoplasm of spinal cord
192.3 Malignant neoplasm of spinal meninges
198.3 Secondary malignant neoplasm of brain and spinal cord
199.0 Disseminated malignant neoplasm
199.1 Other malignant neoplasm of unspecified site
202.80 Other malignant lymphomas, unspecified site, extranodal and solid organ sites
202.90 Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
722.81 Postlaminectomy syndrome, cervical region
722.82 Postlaminectomy syndrome, thoracic region
722.83 Postlaminectomy syndrome, lumbar region
723.1 Cervicalgia

<table>
<thead>
<tr>
<th>Base Unit</th>
<th>Work Value</th>
<th>Non-Fac PE</th>
<th>Fac PE</th>
<th>Malpractice</th>
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<td>3.50</td>
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</table>

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Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir

Explanation
This procedure is performed to allow medication (e.g., cancer chemotherapy, pain management drugs) to be placed into a subcutaneous reservoir for intrathecal or epidural drug infusion. The physician makes a midline incision overlying the placement site. The reservoir is placed in the subcutaneous tissues and attached to a previously placed catheter. Layered sutures are used to close the incision. Report 62360 for subcutaneous reservoir implantation or replacement, 62361 for non-programmable pump implantation or replacement, 62362 for a programmable pump implantation or replacement, and 62365 for removal of the reservoir or pump.

Coding Tips
Two codes are required for reporting implantation of spinal drug infusion devices. Codes 62360–62365 report procedures related to implantation, replacement, or removal of the reservoir or pump only. For implantation, revision, or repositioning of an intrathecal or epidural catheter, without laminectomy, see code 62350; with laminectomy, see code 62351. For removal of a previously implanted intrathecal or epidural catheter, see code 62355. When code 62360, 62361, 62362, or 62365 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For an implantable pump or reservoir refill, see code 96522.

Terms To Know
chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.
subcutaneous reservoir. Space below the skin in which fluid is stored.

ICD-9-CM Diagnostic Codes
191.7 Malignant neoplasm of brain stem
192.2 Malignant neoplasm of spinal cord
193.3 Malignant neoplasm of spinal meninges
198.3 Secondary malignant neoplasm of brain and spinal cord
202.80 Other malignant lymphomas, unspecified site, extranodal and solid organ sites
202.90 Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
722.81 Postlaminectomy syndrome, cervical region
722.82 Postlaminectomy syndrome, thoracic region
722.83 Postlaminectomy syndrome, lumbar region
723.1 Cervicalgia

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Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

Explanation
This procedure is performed to allow medication (e.g., cancer chemotherapy, pain management drugs) to be placed into a subcutaneous reservoir for intrathecal or epidural drug infusion. The physician makes a midline incision overlying the placement site. The reservoir is placed in the subcutaneous tissues and attached to a previously placed catheter. Layered sutures are used to close the incision. Report 62360 for subcutaneous reservoir implantation or replacement, 62361 for non-programmable pump implantation or replacement, 62362 for a programmable pump implantation or replacement, and 62365 for removal of the reservoir or pump.

Coding Tips
Two codes are required for reporting implantation of spinal drug infusion devices. Codes 62360–62365 report procedures related to implantation, replacement, or removal of the reservoir or pump only. For implantation, revision, or repositioning of an intrathecal or epidural catheter, without laminectomy, see code 62350; with laminectomy, see code 62351. For removal of a previously implanted intrathecal or epidural catheter, see code 62355. When code 62365 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For an implantable pump or reservoir refill, see code 96522.

ICD-9-CM Diagnostic Codes
191.7 Malignant neoplasm of brain stem
192.2 Malignant neoplasm of spinal cord
192.3 Malignant neoplasm of spinal meninges
198.3 Secondary malignant neoplasm of brain and spinal cord
202.80 Other malignant lymphomas, unspecified site, extranodal and solid organ sites
202.90 Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
722.81 Postlaminectomy syndrome, cervical region
722.82 Postlaminectomy syndrome, thoracic region
722.83 Postlaminectomy syndrome, lumbar region
723.1 Cervicalgia
724.1 Pain in thoracic spine
724.2 Lumbago
996.2 Mechanical complication of nervous system device, implant, and graft
996.63 Infection and inflammatory reaction due to nervous system device, implant, and graft — (Use additional code to identify specified infections)

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<th>Base Unit</th>
<th>Work Value</th>
<th>Non-Fac PE</th>
<th>Fac PE</th>
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</table>

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

CCC Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**62367-62370**

**62367**  
Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

**62368**  
with reprogramming

**62369**  
with reprogramming and refill

**62370**  
with reprogramming and refill (requiring skill of a physician or other qualified health care professional)

**Explanation**

The physician, physician’s assistant, nurse, or physical therapist places electrodes over the site of a programmable pump and reviews performance of the generator on a computer. Report 62367 if the pump is not reprogrammed or refilled; 62368 if it is reprogrammed; 62369 if it is reprogrammed and refilled; and 62370 if it is reprogrammed, refilled, and requires a physician or other qualified health care professional’s intervention.

**Coding Tips**

This procedure may be performed by a physician or other qualified health care professional. Check with the specific payer to determine coverage. Do not report 62367–62370 in conjunction with 95990–95991. For implantation, revision, or repositioning of an intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump, without laminectomy, see 62350; with laminectomy, see 62351. For removal of a previously implanted intrathecal or epidural catheter, see 62355. For implantation or replacement of a device for intrathecal or epidural drug infusion, subcutaneous reservoir, see 62360; nonprogrammable pump, see 62361; programmable pump, including preparation of pump, with or without programming, see 62362. For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, see 95990–95991.

**Terms To Know**

electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>191.7</td>
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<td>Malignant neoplasm of spinal cord</td>
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<tr>
<td>192.3</td>
<td>Malignant neoplasm of spinal meninges</td>
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<tr>
<td>198.3</td>
<td>Secondary malignant neoplasm of brain and spinal cord</td>
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<tr>
<td>202.80</td>
<td>Other malignant lymphomas, unspecified site, extranodal and solid organ sites</td>
</tr>
<tr>
<td>202.90</td>
<td>Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites</td>
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<tr>
<td>722.81</td>
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<tr>
<td>722.82</td>
<td>Postlaminectomy syndrome, thoracic region</td>
</tr>
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</table>

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0213T, 0216T, 0333T, 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64490, 69990, 92585, 95822, 95860-95870, 95907-95913, 95923-95933, 95937-95940, 96360, 96365, G0453

Also not with 62367: 96522

Also not with 62368: 62367, 96522

Also not with 62369: 62367-62368, 95990-95991

Also not with 62370: 62367-62369, 95990-95991, 96522

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
63650

Percutaneous implantation of neurostimulator electrode array, epidural

Explanation
This procedure is performed to alleviate pain or control spasms. The patient is face down. A standard epidural puncture is made. A thin-walled needle is placed at the appropriate segment. A flexible wire electrode is threaded through the needle under fluoroscopic control. Intraoperative testing is carried out to assure correct electrode positioning creating maximum paresthesia in the pain region. The needle is removed and a dressing applied. A transmitter (pulse generator or receiver) is inserted in a separately reportable procedure. Stimulation may be applied as soon as four days following the procedure.

Coding Tips
Neurostimulator devices consist of two components: an electrode array/plate/paddle and a pulse generator/receiver.

Implantation/placement and revision/removal of each component is reported separately. For laminectomy for implantation of neurostimulator electrodes, plate/paddle, see code 63655. If a spinal neurostimulator electrode percutaneous array, plate/paddle is revised or removed, see codes 63661-63664. For incision and subcutaneous placement of a spinal neurostimulator pulse generator or receiver, see code 63685. If a pulse generator or receiver is revised or removed, see code 63688.

ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>337.00</td>
<td>Idiopathic peripheral autonomic neuropathy, unspecified</td>
</tr>
<tr>
<td>337.21</td>
<td>Reflex sympathetic dystrophy of the upper limb</td>
</tr>
<tr>
<td>337.22</td>
<td>Reflex sympathetic dystrophy of the lower limb</td>
</tr>
<tr>
<td>344.1</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>353.0</td>
<td>Brachial plexus lesions</td>
</tr>
<tr>
<td>353.1</td>
<td>Lumbar sacral plexus lesions</td>
</tr>
<tr>
<td>353.2</td>
<td>Cervical root lesions, not elsewhere classified</td>
</tr>
<tr>
<td>353.3</td>
<td>Thoracic root lesions, not elsewhere classified</td>
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<tr>
<td>353.4</td>
<td>Lumbar sacral root lesions, not elsewhere classified</td>
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<tr>
<td>353.5</td>
<td>Neuralgic amyotrophy — (Code first any associated underlying disease as: 249.6, 250.6)</td>
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<tr>
<td>353.6</td>
<td>Phantom limb (syndrome)</td>
</tr>
<tr>
<td>354.4</td>
<td>Causalgia of upper limb</td>
</tr>
<tr>
<td>354.5</td>
<td>Mononeuritis multiplex</td>
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<tr>
<td>355.0</td>
<td>Lesion of sciatic nerve</td>
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<tr>
<td>355.1</td>
<td>Meralgia paresthetica</td>
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<tr>
<td>355.3</td>
<td>Lesion of lateral popliteal nerve</td>
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<td>Causalgia of lower limb</td>
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<tr>
<td>577.0</td>
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Procedure Codes

<table>
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<td>721.3</td>
<td>Lumbosacral spondylosis without myelopathy</td>
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<td>722.52</td>
<td>Degeneration of lumbar or lumbosacral intervertebral disc</td>
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<td>722.73</td>
<td>Intervertebral lumbar disc disorder with myelopathy, lumbar region</td>
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<td>722.81</td>
<td>Postlaminectomy syndrome, cervical region</td>
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<tr>
<td>722.82</td>
<td>Postlaminectomy syndrome, thoracic region</td>
</tr>
<tr>
<td>722.83</td>
<td>Postlaminectomy syndrome, lumbar region</td>
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<tr>
<td>723.1</td>
<td>Cervicalgia</td>
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<tr>
<td>723.4</td>
<td>Brachial neuritis or radiculitis NOS</td>
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<td>724.02</td>
<td>Spinal stenosis of lumbar region, without neurogenic claudication</td>
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<td>724.1</td>
<td>Pain in thoracic spine</td>
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<td>724.2</td>
<td>Lumbago</td>
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<td>Sciatica</td>
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<td>724.4</td>
<td>Thoracic or lumbosacral neuritis or radiculitis, unspecified</td>
</tr>
<tr>
<td>729.2</td>
<td>Unspecified neuralgia, neuritis, and radiculitis</td>
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<td>729.5</td>
<td>Pain in soft tissues of limb</td>
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<tr>
<td>731.0</td>
<td>Osteitis deformans without mention of bone tumor</td>
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<tr>
<td>905.1</td>
<td>Late effect of fracture of spine and trunk without mention of spinal cord lesion</td>
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<td>905.2</td>
<td>Late effect of fracture of upper extremities</td>
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<td>905.3</td>
<td>Late effect of fracture of neck of femur</td>
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<td>905.4</td>
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<td>907.2</td>
<td>Late effect of spinal cord injury</td>
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<td>907.3</td>
<td>Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk</td>
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<tr>
<td>907.4</td>
<td>Late effect of injury to peripheral nerve of shoulder girdle and upper limb</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</table>

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Explanation
This procedure is performed to alleviate pain or control spasms. The patient is face down. The physician makes a midline incision overlying the affected vertebrae. The fascia are incised. The paravertebral muscles are retracted. The lamina is removed to expose the epidural space. The physician places passive electrodes or plates or paddles in the epidural space proximate to the desired spine segment. Paravertebral muscles are reapproximated and the incision is closed with layered sutures. A transmitter (pulse generator or receiver) is inserted in a separately reportable procedure. Stimulation may be applied as soon as four days following the procedures.

Coding Tips
Neurostimulator devices consist of two components: an electrode array/plate/paddle and a pulse generator/receiver. Implantation/placement and revision/removal of each component is reported separately. For percutaneous implantation of a neurostimulator electrode array, see code 63650. For incision and subcutaneous placement of a spinal neurostimulator pulse generator or receiver, see code 63685. If a spinal neurostimulator electrode percutaneous array or plate/paddle is revised or removed, see codes 63661-63664. If a pulse generator or receiver is revised or removed, see code 63688.

ICD-9-CM Diagnostic Codes
337.00  Idiopathic peripheral autonomic neuropathy, unspecified
337.21  Reflex sympathetic dystrophy of the upper limb
337.22  Reflex sympathetic dystrophy of the lower limb
337.29  Reflex sympathetic dystrophy of other specified site
344.1  Paraplegia
353.0  Brachial plexus lesions
353.1  Lumbosacral plexus lesions
353.2  Cervical root lesions, not elsewhere classified
353.3  Thoracic root lesions, not elsewhere classified
353.4  Lumbosacral root lesions, not elsewhere classified
353.5  Neuralgic amyotrophy — (Code first any associated underlying disease as: 249.6, 250.6)
353.6  Phantom limb (syndrome)
354.4  Causalgia of upper limb
354.5  Mononeuritis multiplex
355.0  Lesion of sciatic nerve
355.1  Meralgia paresthetica
355.3  Lesion of lateral popliteal nerve
355.4  Lesion of medial popliteal nerve
355.6  Lesion of plantar nerve
355.71  Causalgia of lower limb
577.0  Acute pancreatitis
577.1  Chronic pancreatitis
721.3  Lumbosacral spondylolisthesis without myelopathy
722.52  Degeneration of lumbar or lumbosacral intervertebral disc
722.73  Intervertebral lumbar disc disorder with myelopathy, lumbar region
722.81  Postlaminectomy syndrome, cervical region
722.82  Postlaminectomy syndrome, thoracic region
722.83  Postlaminectomy syndrome, lumbar region
723.1  Cervicalgia
723.4  Brachial neuritis or radiculitis NOS
724.02  Spinal stenosis of lumbar region, without neurogenic claudication
724.1  Pain in thoracic spine
724.2  Lumbar pain
724.3  Sciatica
724.4  Thoracic or lumbosacral neuritis or radiculitis, unspecified
729.5  Pain in soft tissues of limb
731.0  Osteitis deformans without mention of bone tumor
905.1  Late effect of fracture of spine and trunk without mention of spinal cord lesion
905.2  Late effect of fracture of upper extremities
905.3  Late effect of fracture of neck of femur
905.4  Late effect of fracture of lower extremities
905.5  Late effect of fracture of multiple and unspecified bones
907.2  Late effect of spinal cord injury
907.3  Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk
907.4  Late effect of injury to peripheral nerve of shoulder girdle and upper limb

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<th>Work Value</th>
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Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

**Explanation**

The physician removes spinal neurostimulator electrode percutaneous arrays (63661) or spinal neurostimulator plates or paddles that were placed via laminotomy or laminectomy (63662). The patient is face down (prone). The physician makes a midline incision overlying the affected vertebrae. The fascia is incised. The paravertebral muscles are retracted. The physician removes the electrode plates or paddles in the epidural space proximate to the spine segment. Stimulation is applied. These codes include the use of fluoroscopic guidance, when performed.

**Coding Tips**

Do not report 63663–63664 in conjunction with 63661 or 63662 when performed at the same spinal level.

**Terms To Know**

- **Electrode**: Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.
- **Laminectomy**: Removal or excision of the posterior arch of a vertebra to provide additional space for the nerves and widen the spinal canal.
- **Laminotomy**: Surgical incision to divide the lamina, forming the posterior arch of a vertebra, to take pressure off nerve roots, sometimes caused by the rupture of a herniated vertebral disk.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**


Also not with 63661: 01935-01936

Also not with 63662: 62263, 63650

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
<thead>
<tr>
<th>Base Unit</th>
<th>Work Value</th>
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Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

Explanation
The physician revises neurostimulator electrode percutaneous arrays or neurostimulator electrode plates or paddles that were placed via laminotomy or laminectomy. Replacement of these devices may also be performed. The patient is face down (prone). The physician makes a midline incision overlying the affected vertebrae. The fascia is incised. The paravertebral muscles are retracted. The physician revises the electrodes or plates or paddles in the epidural space proximate to the spine segment or moves them to a new vertebral segment. Stimulation is applied. These codes include fluoroscopic guidance, when performed. Report 63664 when the original electrodes were placed percutaneously. Report 63664 when the electrodes were originally placed via laminotomy or laminectomy or if a laminectomy is performed to gain access to the epidural space in the event of movement to a new segment.

Coding Tips
Do not report code 63663 or 63664 with code 63661 or 63662 when performed on the same spinal level.

Terms To Know
electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.
laminectomy. Removal or excision of the posterior arch of a vertebra to provide additional space for the nerves and widen the spinal canal.
laminotomy. Surgical incision to divide the lamina, forming the posterior arch of a vertebra, to take pressure off nerve roots, sometimes caused by the rupture of a herniated vertebral disk.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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<tr>
<th>Base Unit</th>
<th>Work Value</th>
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<th>Fac PE</th>
<th>Malpractice</th>
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</table>

63685

Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

Explanation

The physician inserts or replaces a spinal neurostimulator pulse generator or receiver into a subcutaneous pocket. Placing a spinal neurostimulator is often done to treat cases of intractable pain. The physician selects a location site, usually the abdominal area, and incises the skin. Using blunt dissection, the physician creates a pocket for the generator or receiver. The unit is connected to a previously placed electrode, which is separately implanted and normally positioned in a dural/epidural pocket over the spinal cord of the affected vertebral area. After ensuring that the device is functioning, the generator or receiver is sutured into place within its subcutaneous pocket.

Coding Tips

Neurostimulator devices consist of two components: an electrode array/plate/paddle and a pulse generator/receiver. Implantation/placement and revision/removal of each component is reported separately. Do not report revision or removal of an implanted spinal neurostimulator pulse generator or receiver (63688) with code 63685. For implantation of a neurostimulator electrode array/plate/paddle, see codes 63650 and 63655. If a spinal neurostimulator electrode percutaneous array or plate/paddle is revised or removed, see codes 63661-63664. See codes 95970-95975 for the electronic analysis of an implanted neurostimulator pulse generator system.

Terms To Know

dissemination. Separating by cutting tissue or body structures apart.
edector. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.
pulse generator. Circuit used to generate pulses. Pulse generators contain the battery, the electronic circuit, and the connector in a hermetically sealed encasement. Pulse generators may be temporary transcutaneous or placed in a subcutaneous pocket.
subcutaneous pocket. Small space created under the skin in a suitable location for holding an implantable device, such as the pulse generator of a pacemaker or cardioverter defibrillator.

ICD-9-CM Diagnostic Codes

053.19 Other herpes zoster with nervous system complications
337.21 Reflex sympathetic dystrophy of the upper limb
337.22 Reflex sympathetic dystrophy of the lower limb
353.3 Thoracic root lesions, not elsewhere classified
353.4 Lumbosacral root lesions, not elsewhere classified
353.6 Phantom limb (syndrome)
353.8 Other nerve root and plexus disorders
354.4 Causalgia of upper limb
355.71 Causalgia of lower limb

Procedure Codes

440.22 Atherosclerosis of native arteries of the extremities with rest pain
721.2 Thoracic spondylosis without myelopathy
721.3 Lumbosacral spondylosis without myelopathy
722.10 Displacement of lumbar intervertebral disc without myelopathy
722.11 Displacement of thoracic intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.51 Degeneration of thoracic or thoracolumbar intervertebral disc
722.52 Degeneration of lumbar or lumbosacral intervertebral disc
722.81 Postlaminecotomy syndrome, cervical region
722.82 Postlaminecotomy syndrome, thoracic region
722.83 Postlaminecotomy syndrome, lumbar region
723.4 Brachial neuritis or radiculitis NOS
724.2 Lumbago
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
952.4 Cauda equina spinal cord injury without spinal bone injury
953.2 Injury to lumbar nerve root
996.2 Mechanical complication of nervous system device, implant, and graft
996.63 Infection and inflammatory reaction due to nervous system device, implant, and graft — (Use additional code to identify specified infections)
996.75 Other complications due to nervous system device, implant, and graft — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
</table>

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Explanation
This procedure is performed to promote nerve regeneration. The patient is placed in a prone. The physician makes a midline incision overlying the affected vertebrae. The fascia is incised. The paravertebral muscles are retracted. The physician moves or removes the direct electrode needles or inductive electrode pads in or on the epidural space proximate to the damaged spine segment, placing them in the right plane. The generator or receiver is moved or removed over sutured muscles but below the skin. Layered sutures are used to close the incision.

Coding Tips
Neurostimulator devices consist of two components: an electrode array/plate/paddle and a pulse generator/receiver. Implantation/placement and revision/removal of each component is reported separately. Do not report replacement of an implanted spinal neurostimulator pulse generator or receiver (63685) with code 63688.

For implantation of a neurostimulator electrode array/plate/paddle, see codes 63650 and 63655. If a spinal neurostimulator electrode percutaneous array or plate/paddle is revised or removed, see codes 63661-63664. For electronic analysis of an implanted neurostimulator pulse generator system, see codes 95970-95975.

Terms To Know
electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.
fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
prone. Lying face downward.
regeneration. Process of reproducing or regrowing tissue.

ICD-9-CM Diagnostic Codes
349.1 Nervous system complications from surgically implanted device
353.8 Other nerve root and plexus disorders
721.3 Lumbosacral spondylosis without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.83 Postlaminectomy syndrome, lumbar region
724.2 Lumbago
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
729.5 Pain in soft tissues of limb
953.2 Injury to lumbar nerve root
996.2 Mechanical complication of nervous system device, implant, and graft

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>CPT Code</th>
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<td>Revision or removal of implanted spinal neurostimulator pulse generator or receiver</td>
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<td>5.30</td>
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</table>

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
64400-64405

64400 Injection, anesthetic agent; trigeminal nerve, any division or branch
64402 facial nerve
64405 greater occipital nerve

Explanation
The physician anesthetizes a branch of the trigeminal nerve in 64400, the facial nerve in 64402, or the greater occipital nerve in 64405. The trigeminal nerve supplies sensory and motor fibers to the face, and is usually blocked superficially. The facial nerve supplies motor fibers to the muscles of facial expression. The greater occipital nerve supplies sensory fibers to the scalp. The physician draws a local anesthetic into a syringe and injects it into the branch of the nerve to be anesthetized.

Coding Tips
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For trigeminal nerve destruction by neurolytic agent, see codes 64600-64610. For transection of avulsion or trigeminal nerve branches, see codes 64734-64738. For facial nerve destruction by neurolytic agent, see code 64612. For transection or avulsion of facial nerve, see code 64742. For transection or avulsion of greater occipital nerve, see code 64744.

ICD-9-CM Diagnostic Codes
- 350.1 Trigeminal neuralgia
- 350.2 Atypical face pain
- 729.1 Unspecified myalgia and myositis

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

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<table>
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<th>Procedure Code</th>
<th>Base Unit</th>
<th>Work Value</th>
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</table>

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### 64408

**Explanation**
The physician anesthetizes the vagus nerve. The vagus nerve supplies sensory fibers to the pharynx and glottis, and carries parasympathetic fibers to the digestive system and heart. The physician draws a local anesthetic into a syringe and injects it in the branch of the nerve proximal to the area to be anesthetized.

**Coding Tips**
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For transection or avulsion of vagus nerve (vagotomy) by open approach, see codes 64752-64760; by laparoscopic approach, see codes 43631-43652.

**Terms To Know**
**vagotomy.** Division of the vagus nerves, interrupting impulses resulting in lower gastric acid production and hastening gastric emptying.

**ICD-9-CM Diagnostic Codes**
352.3  Disorders of pneumogastric (10th) nerve
536.1  Acute dilatation of stomach

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**

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<table>
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<th>Base Unit</th>
<th>Work Value</th>
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</tbody>
</table>

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The physician anesthetizes the phrenic nerve to limit motor control of the diaphragm. The physician draws a local anesthetic into a syringe and injects it in the nerve. This anesthesia would be supplied in cases of unending hiccups, or diagnostically to predict the effect of nerve loss.

**Coding Tips**

Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For transection or avulsion of the phrenic nerve, see code 64746.

**Terms To Know**

**diaphragm.** Muscular wall separating the thorax and its structures from the abdomen.

**phrenic nerves.** Two nerves that arise mainly from the fourth cervical nerve, providing motor nerve function to a side of the diaphragm and serve in the breathing function. The right nerve plays a role in liver function.

**ICD-9-CM Diagnostic Codes**

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<tr>
<th>Code</th>
<th>Description</th>
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<td>353.2</td>
<td>Cervical root lesions, not elsewhere classified</td>
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<tr>
<td>519.4</td>
<td>Disorders of diaphragm — (Use additional code to identify infectious organism)</td>
</tr>
<tr>
<td>786.8</td>
<td>Hiccough</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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64412

**Explanation**
The physician anesthetizes the spinal accessory nerve to limit sensation in the trapezius and lower neck. The physician draws a local anesthetic into the syringe and injects it into the branch of the nerve proximal to the area to be anesthetized.

**Coding Tips**
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office.

**Terms To Know**
INJ. Injection
injection. Forcing a liquid substance into a body part such as a joint or muscle.

**ICD-9-CM Diagnostic Codes**
333.83 Spasmodic torticollis — (Use additional E code to identify drug, if drug-induced)
352.4 Disorders of accessory (11th) nerve

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**

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**Explanation**

The physician anesthetizes the cervical plexus for sympathetically mediated pain and anesthesia to the back of the neck and head. The physician draws a local anesthetic into three syringes and injects near the transverse processes of C2 to C4, avoiding vascular injection.

**Coding Tips**

Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For injections of anesthetic agents in the brachial plexus, see codes 64415 and 64416.

**Terms To Know**

**INJ.** Injection.

**Injection.** Forcing a liquid substance into a body part such as a joint or muscle.

**ICD-9-CM Diagnostic Codes**

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<td>Cervical spondylosis with myelopathy</td>
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<td>722.0</td>
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<td>Degeneration of cervical intervertebral disc</td>
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<td>847.1</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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**64415-64416**

**64415**  Injection, anesthetic agent; brachial plexus, single

**64416**  brachial plexus, continuous infusion by catheter (including catheter placement)

**Explanation**

The physician anesthetizes the brachial plexus with a single injection to provide anesthesia and pain control to the arm in 64415. The physician draws a local anesthetic into the syringe and injects it into the brachial plexus, approached in one of three locations: intrascalene, supraclavicular, or axillary. In 64416, continuous infusion of local anesthetic through a catheter is done to provide a nerve block lasting longer than the block effect achieved through a single injection. An indwelling catheter is placed and positioned so as to provide anesthesia to the brachial plexus. An infusion pump is connected to the catheter to supply a continuous flow of infused anesthetic agent at a set rate. The infusion system may be used for regional surgical anesthesia when general anesthesia is not required and for postoperative pain management. Catheter placement is included in 64416 and is not reported separately.

**Coding Tips**

Do not report code 64416 with 01996. For anesthesia by injection performed by a different provider, see codes 01991 and 01992. Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office.

**Terms To Know**

- **brachial plexus.** Large bundle of nerves originating in the C5 to T2 spinal segments, terminating in the neck, axilla, and subclavicular area, used as an anatomic landmark for administration of pain management medication.

- **catheter.** Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

- **infusion pump.** Device that delivers a measured amount of drug or intravenous solution through injection over a period of time.

- **regional anesthesia.** Anesthesia administered to a nerve or nerve plexus to provide a loss of sensation in a particular region, without inducing unconsciousness. Sometimes sedative agents are administered, such as Valium, prior to administration of the regional anesthesia.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
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<td>Reflex sympathetic dystrophy of the upper limb</td>
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<tr>
<td>353.0</td>
<td>Brachial plexus lesions</td>
</tr>
<tr>
<td>354.4</td>
<td>Causalgia of upper limb</td>
</tr>
<tr>
<td>357.81</td>
<td>Chronic inflammatory demyelinating polyneuritis</td>
</tr>
<tr>
<td>357.89</td>
<td>Other inflammatory and toxic neuropathy</td>
</tr>
<tr>
<td>716.11</td>
<td>Traumatic arthropathy, shoulder region</td>
</tr>
<tr>
<td>719.41</td>
<td>Pain in joint, shoulder region</td>
</tr>
<tr>
<td>719.42</td>
<td>Pain in joint, upper arm</td>
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<tr>
<td>723.4</td>
<td>Brachial neuritis or radiculitis NOS</td>
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<tr>
<td>729.1</td>
<td>Unspecified myalgia and myositis</td>
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</table>

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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**


Also not with 64415: S1701-S1702, J0670
Also not with 64416: 01996, 36000, 36410, S1701-S1703

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
64417

64417 Injection, anesthetic agent; axillary nerve

Explanation
The physician anesthetizes the axillary nerve to provide anesthesia to the shoulder. The physician draws a local anesthetic into a syringe and injects the nerve blocking agent into the axillary nerve.

Coding Tips
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office.

Terms To Know
- axillary. Area under the arm.
- nerve block. Regional anesthesia/analgesia administered by injection that prevents sensory nerve impulses from reaching the central nervous system.

ICD-9-CM Diagnostic Codes
- 337.21 Reflex sympathetic dystrophy of the upper limb
- 353.0 Brachial plexus lesions
- 354.4 Causalgia of upper limb
- 357.81 Chronic inflammatory demyelinating polynueritis
- 357.89 Other inflammatory and toxic neuropathy
- 716.11 Traumatic arthropathy, shoulder region
- 719.41 Pain in joint, shoulder region
- 719.42 Pain in joint, upper arm
- 723.4 Brachial neuritis or radiculitis NOS
- 729.1 Unspecified myalgia and myositis
- 729.5 Pain in soft tissues of limb
- 840.4 Rotator cuff (capsule) sprain and strain
- 953.4 Injury to brachial plexus

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

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64418

64418  Injection, anesthetic agent; suprascapular nerve

Explanation
The physician anesthetizes the suprascapular nerve to relax the supraspinatus and infraspinatus muscles and differentiate between brachial plexus mediated or C5 or C6 mediated pain. The physician draws a local anesthetic into the syringe and injects it into the suprascapular nerve.

Coding Tips
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For injections of anesthetic agents in the brachial plexus, see codes 64415 and 64416.

ICD-9-CM Diagnostic Codes
- 357.81  Chronic inflammatory demyelinating polyneuritis
- 357.89  Other inflammatory and toxic neuropathy
- 718.31  Recurrent dislocation of shoulder joint
- 719.41  Pain in joint, shoulder region
- 723.1  Cervicalgia
- 723.4  Brachial neuritis or radiculitis NOS
- 726.11  Calcifying tendinitis of shoulder
- 728.85  Spasm of muscle
- 729.1  Unspecified myalgia and myositis
- 729.2  Unspecified neuralgia, neuritis, and radiculitis
- 729.5  Pain in soft tissues of limb

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

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64420-64421

**64420** Injection, anesthetic agent; intercostal nerve, single

**64421** intercostal nerves, multiple, regional block

**Explanation**
The physician anesthetizes the intercostal nerve to block chest wall pain. In 64420, a single injection is performed. In 64421, multiple nerves are injected to provide pain relief to a larger area (regional block).

**Coding Tips**
For destruction of an intercostal nerve by a neurolytic agent, see code 64620.

**Terms To Know**

*regional anesthesia.* Anesthesia administered to a nerve or nerve plexus to provide a loss of sensation in a particular region, without inducing unconsciousness. Sometimes sedative agents are administered, such as Valium, prior to administration of the regional anesthesia.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**

Also not with 64421: 64420

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**64425**

**Explanation**
The physician anesthetizes the ilioinguinal and iliohypogastric nerves to block the inguinal and lower abdomen for pain control. The physician draws a local anesthetic into the syringe and injects it in a fan-like manner medial to the hip bone toward the umbilicus.

**Coding Tips**
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For injections of anesthetic agents in the paracervical nerve, see code 64435.

**Terms To Know**
- **ilio-**: Relating to the pelvis.
- **inguinal**: Within the groin region.

**ICD-9-CM Diagnostic Codes**
- 185 Malignant neoplasm of prostate
- 195.2 Malignant neoplasm of abdomen
- 337.9 Unspecified disorder of autonomic nervous system
- 355.1 Meralgia paresthetica
- 355.2 Other lesion of femoral nerve
- 355.3 Lesion of lateral popliteal nerve
- 355.4 Lesion of medial popliteal nerve
- 355.5 Tarsal tunnel syndrome
- 355.6 Lesion of plantar nerve
- 355.79 Other mononeuritis of lower limb
- 355.8 Unspecified mononeuritis of lower limb
- 355.9 Mononeuritis of unspecified site
- 550.90 Inguinal hernia without mention of obstruction or gangrene, unilateral or unspecified, (not specified as recurrent)
- 603.8 Other specified type of hydrocele
- 607.1 Balanoposthitis — (Use additional code to identify organism)
- 608.1 Spermatocele
- 721.42 Spondylosis with myelopathy, lumbar region
- 724.2 Lumbago
- 729.2 Unspecified neuralgia, neuritis, and radiculitis
- 729.5 Pain in soft tissues of limb

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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CCI Version 20.0


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
64430-64435

64430  Injection, anesthetic agent; pudendal nerve
64435  paracervical (uterine) nerve

Explanation
The physician anesthetizes the pudendal nerve for anesthesia of the perineum, rectum, and parts of the bladder and genitals. In 64430, the pudendal nerve is blocked, typically for perineal pain control, for example, during vaginal delivery. Code 64435 is a female-only procedure in which the area around the cervix is injected with a local anesthetic to supply pain control for the first stage of labor.

Coding Tips
Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office. For destruction of the pudendal nerve by a neurolytic agent, see code 64630.

Terms To Know
local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.
perineal. Pertaining to the pelvic floor area between the thighs; the diamond-shaped area bordered by the pubic symphysis in front, the ischial tuberosities on the sides, and the coccyx in back.
pudendal nerve. Nerve that serves most of the perineum and the external anal sphincter and provides sensation to the external genitalia.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
Also not with 64430: 20550-20553
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Explanation
The physician anesthetizes the sciatic nerve with a single injection to provide anesthesia and pain control for the distal lower extremity. The physician draws a local anesthetic into the syringe and injects it into the sciatic nerve.

Coding Tips
These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Code 01996 should not be reported with code 64446. Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office.

Terms To Know
infusion pump. Device that delivers a measured amount of drug or intravenous solution through injection over a period of time.
injection. Forcing a liquid substance into a body part such as a joint or muscle.
regional anesthesia. Anesthesia administered to a nerve or nerve plexus to provide a loss of sensation in a particular region, without inducing unconsciousness. Sometimes sedative agents are administered, such as Valium, prior to administration of the regional anesthesia.
sciatic nerve. Largest nerve in the body that arises from the sacral plexus and innervates all of the muscles of the leg and foot.

ICD-9-CM Diagnostic Codes
355.0 Lesion of sciatic nerve
355.79 Other mononeuritis of lower limb
357.81 Chronic inflammatory demyelinating polyneuritis
357.89 Other inflammatory and toxic neuropathy
719.45 Pain in joint, pelvic region and thigh
720.2 Sacroilitis, not elsewhere classified
721.42 Spondylitis with myelopathy, lumbar region
722.10 Displacement of lumbar intervertebral disc without myelopathy
722.52 Degeneration of lumbar or lumbosacral intervertebral disc
722.83 Postlaminectomy syndrome, lumbar region
724.02 Spinal stenosis of lumbar region, without neurogenic claudication
724.2 Lumbago
724.3 Sciatica
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified

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64447-64448

64447  Injection, anesthetic agent; femoral nerve, single
64448  femoral nerve, continuous infusion by catheter (including catheter placement)

Explanation
The physician anesthetizes the femoral nerve with a single injection to provide anesthesia and pain control for the lower extremity in 64447. The physician draws a local anesthetic into the syringe and injects it into the femoral nerve. In 64448, continuous infusion of local anesthetic through a catheter is done to provide a nerve block lasting longer than a single injection. An indwelling catheter is placed and positioned so as to provide anesthesia to the femoral nerve. An infusion pump is connected to the catheter to supply a continuous flow of infused anesthetic agent at a set rate. The infusion system may be used for regional surgical anesthesia when general anesthesia is not required and for postoperative pain management.

Coding Tips
These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Fluoroscopic guidance is reported separately, see code 77003. Do not report codes 64447–64448 with 01996.

Terms To Know
infusion pump. Device that delivers a measured amount of drug or intravenous solution through injection over a period of time.
regional anesthesia. Anesthesia administered to a nerve or nerve plexus to provide a loss of sensation in a particular region, without inducing unconsciousness. Sometimes sedative agents are administered, such as Valium, prior to administration of the regional anesthesia.

ICD-9-CM Diagnostic Codes
355.1  Meralgia paresthetica
355.2  Other lesion of femoral nerve
355.71  Causalgia of lower limb
355.79  Other mononeuritis of lower limb
719.45  Pain in joint, pelvic region and thigh
726.5  Enthesopathy of hip region
726.61  Pes anserinus tendinitis or bursitis
726.62  Tibial collateral ligament bursitis
726.63  Fibular collateral ligament bursitis
726.65  Prepatellar bursitis
726.69  Other enthesisopathy of knee
729.1  Unspecified myalgia and myositis
729.2  Unspecified neuralgia, neuritis, and radiculitis
729.5  Pain in soft tissues of limb

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
**64449-64450**

**64449**  
Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

**64450**  
other peripheral nerve or branch

**Explanation**
The physician performs a nerve block, posterior approach, on the lumbar plexus by infusing an anesthetic agent through a catheter placed for daily management of pain and administration of anesthesia. The lumbar plexus is formed from the nerve branches in the psoas major muscle: the ilioinguinal, obturator, iliohypogastric, lateral femoral cutaneous, genito-femoral, and the femoral nerves. IV sedatives and analgesics are set up. With the patient in the right lateral decubitus position, the insertion point for the needle is marked. Local anesthetic is also given. The needle is advanced toward the lumbar plexus, avoiding any transverse processes of the lumbar vertebrae until it is in proper position within the compartment of the psoas muscle, and stimulation of the plexus is seen by the contraction of certain muscles. Blood and cerebral spinal fluid is aspirated. After determining that the needle is in the correct position and that the injection will not go intravenously or intrathecally, local anesthesia is injected through the needle, and an infusion catheter is fed through the needle past the tip. Catheter placement is also checked, the catheter is secured in place, and continuous infusion is begun.

**Coding Tips**
Do not report code 64449 with 01996. Report the drug used in the injection with the appropriate HCPCS Level II code when the procedure is performed in the physician office.

**Terms To Know**

- **cerebrospinal fluid.** Thin, clear fluid circulating in the cranial cavity and spinal column that bathes the brain and spinal cord.
- **lumbar plexus.** Network of spinal nerves from lumbar levels L1-L4 that supplies motor, sensory, and autonomic fibers to the lower extremity, as well as the gluteal and inguinal regions along with the sacral plexus.

**ICD-9-CM Diagnostic Codes**

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<th>Code</th>
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<td>Other nerve root and plexus disorders</td>
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<td>Other mononeuritis of lower limb</td>
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<td>Spinal enthesopathy</td>
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<td>Lumbosacral spondylodisc without myelopathy</td>
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<td>721.42</td>
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Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

64479: cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Explanation
The physician injects anesthetic and/or steroid into the epidural space using a transforaminal approach. This approach is used primarily in the treatment of herniated discs and requires separately reportable fluoroscopic direction. The injection may be performed on a single or multiple cervical or thoracic level. Report 64479 for a single level; report 64480 for each additional level.

Coding Tips
As an add-on code, 64480 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Use 64480 in conjunction with 64479. These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For transforaminal epidural injections under ultrasound guidance, see 0228T–0229T. Imaging guidance provided via CT or fluoroscopy is included in 64479–64480.

Terms To Know
transforaminal. Across, beyond, or through a natural opening, passage, or channel within the body. Transforaminal generally refers to the large central passage within the vertebrae that forms the canal for the spinal cord.

ICD-9-CM Diagnostic Codes
353.5 Neuralgic amyotrophy — (Code first any associated underlying disease as: 249.6, 250.6)
353.6 Phantom limb (syndrome)
720.0 Ankylosing spondylitis
720.1 Spinal enthesopathy
721.0 Cervical spondylosis without myelopathy
721.1 Cervical spondylosis with myelopathy
721.2 Thoracic spondylosis without myelopathy
721.41 Spondylosis with myelopathy, thoracic region
721.6 Ankylosing vertebral hyperosteosis
721.7 Traumatic spondylolysis
722.0 Displacement of cervical intervertebral disc without myelopathy
722.11 Displacement of thoracic intervertebral disc without myelopathy
722.31 Schmorl's nodes, thoracic region
722.4 Degeneration of cervical intervertebral disc
722.51 Degeneration of thoracic or thoracolumbar intervertebral disc
722.71 Intervertebral cervical disc disorder with myelopathy, cervical region
722.72 Intervertebral thoracic disc disorder with myelopathy, thoracic region
722.81 Postlaminectomy syndrome, cervical region
722.82 Postlaminectomy syndrome, thoracic region
722.92 Other and unspecified disc disorder of thoracic region
723.0 Spinal stenosis in cervical region
723.1 Cervicalgia
723.2 Cervicocranial syndrome
723.3 Cervicobrachial syndrome (diffuse)
723.4 Brachial neuritis or radiculitis NOS
724.01 Spinal stenosis of thoracic region
724.1 Pain in thoracic spine
724.4 Thoracic or lumbar sacral neuritis or radiculitis, unspecified
847.0 Neck sprain and strain
847.1 Thoracic sprain and strain

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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01991-01992, 0282T-0285T, 0333T, 69990, 76000-76001, 76800, 76942, 76998, 77012, 92585, 93000-93010, 93040-93042, 95822, 95860-95866, 95907-95913, 95937-95940, G0453, G0459
Also not with 64480: 0229T, 77002-77003, 95869, 95925-95927, 95930-95933

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<th>Procedure Codes</th>
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</table>
Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

64483-64484

Explanation

The physician injects anesthetic and/or steroid into the epidural space using a transforaminal approach. This approach is used primarily in the treatment of herniated discs and requires separately reportable fluoroscopic direction. The injection may be performed on a single or multiple lumbar or sacral level. Report 64483 for a single level; report 64484 for each additional level.

Coding Tips

As an add-on code, 64484 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Use 64484 in conjunction with 64483. These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For transforaminal epidural injections under ultrasound guidance, see 0230T–0231T. Imaging guidance provided via CT or fluoroscopy is included in 64483 and 64484.

Terms To Know

epidural space. Area between the dura mater and the interior surface of the spinal canal, containing fat, veins, and arteries.

transforaminal. Across, beyond, or through a natural opening, passage, or channel within the body. Transforaminal generally refers to the large central passage within the vertebrae that forms the canal for the spinal cord.

ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
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<td>Lumbosacral root lesions, not elsewhere classified</td>
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<tr>
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<td>Other nerve root and plexus disorders</td>
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<tr>
<td>355.79</td>
<td>Other mononeuritis of lower limb</td>
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<tr>
<td>719.45</td>
<td>Pain in joint, pelvic region and thigh</td>
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<td>Pain in joint, other specified sites</td>
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01991-01992, 0282T-0285T, 0333T, 76000-76001, 76800, 76942, 76998, 77012, 92585, 93000-93010, 93040-93042, 95822, 95860-95866, 95907-95913, 95937-95940, 90453, 90459


Also not with 64484: 0231T, 77002-77003, 95869, 95925-95927, 95930-95933

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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ICD-9-CM Diagnostic Codes

- 353.2  Cervical root lesions, not elsewhere classified
- 353.3  Thoracic root lesions, not elsewhere classified
- 353.5  Neuropathic amyotrophy — (Code first any associated underlying disease as: 249.6, 250.6)
- 353.6  Phantom limb (syndrome)
- 353.8  Other nerve root and plexus disorders
- 720.0  Ankylosing spondylitis
- 720.1  Spinal enthesopathy
- 721.0  Cervical spondylodiscitis without myelopathy
- 721.1  Cervical spondylodiscitis with myelopathy
- 721.2  Thoracic spondylodiscitis without myelopathy
- 721.41  Spondylitis with myelopathy, thoracic region
- 721.6  Ankylosing vertebral hyperostosis
- 721.7  Traumatic spondylodiscitis
- 722.0  Displacement of cervical intervertebral disc without myelopathy
- 722.11  Displacement of thoracic intervertebral disc without myelopathy
- 722.31  Schmorl’s nodes, thoracic region
- 722.4  Degeneration of cervical intervertebral disc
- 722.51  Degeneration of thoracic or thoracolumbar intervertebral disc
- 722.71  Intervertebral disc disorder with myelopathy, cervical region
- 722.72  Intervertebral thoracic disc disorder with myelopathy, thoracic region
- 722.81  Postlaminectomy syndrome, cervical region
- 722.82  Postlaminectomy syndrome, thoracic region
- 723.0  Spinal stenosis in cervical region
- 723.1  Cervicalgia
- 723.2  Cervicocranial syndrome
- 723.3  Cervicobrachial syndrome (diffuse)
- 723.4  Brachial neuritis or radiculitis NOS
- 723.6  Panniculitis specified as affecting neck
- 723.8  Other syndromes affecting cervical region
- 724.01  Spinal stenosis of thoracic region
- 724.1  Pain in thoracic spine
- 847.0  Neck sprain and strain
- 847.1  Thoracic sprain and strain

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Also not with 64490: 0178T-0179T, 0180T, 01991-01992, 2075T-2080T, 20800-20805, 20600-20605, 20610, 36140, 36410, 7225, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99495-99496, G0459

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

64493
second level (List separately in addition to code for primary procedure)

64494
third and any additional level(s) (List separately in addition to code for primary procedure)

Explanation
The physician injects a diagnostic or therapeutic agent into a lumbar or sacral paravertebral facet joint or into the nerves that innervate the joint using fluoroscopic or CT guidance. The paravertebral facet joints, also called zygapophyseal or “Z” joints, consist of the bony surfaces between the vertebrae that articulate with each other. The injection may be performed on a single level or on multiple levels. Report 64493 for a single level, 64494 for a second level, and 64495 for the third and any additional levels.

Coding Tips
Image guidance (fluoroscopic or CT) is required for these procedures. If the service is not performed with image guidance, see codes 20550-20553. When ultrasound guidance is used, report code 0213T-0218T. These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier S1 appended to the second code while others require identification of the service only once with modifier S1 appended. Check with individual payers. Modifier S1 identifies a procedure performed identically on the opposite side of the body (mirror image). Code 64495 should be reported only once daily. As add-on codes, 64494 and 64495 are not subject to multiple procedure rules. No reimbursement reduction or modifier S1 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Use 64494 and 64495 in conjunction with 64493.

ICD-9-CM Diagnostic Codes

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<tr>
<td>353.4</td>
<td>Lumbosacral root lesions, not elsewhere classified</td>
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<td>353.6</td>
<td>Phantom limb (syndrome)</td>
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<tr>
<td>353.8</td>
<td>Other nerve root and plexus disorders</td>
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<td>355.0</td>
<td>Lesion of sciatic nerve</td>
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<td>355.79</td>
<td>Other mononeuropathies of lower limb</td>
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<td>Ankylosing vertebral hyperostosis</td>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Explaination

The physician injects the sphenopalatine ganglion nerve with an anesthetic agent to provide anesthesia to the nasal mucosa. The anesthesia is applied by entering through the nares and injecting cocaine posterior to the middle turbinate.

Coding Tips

Local anesthesia is included in these services. Fluoroscopic guidance is reported separately. This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For injections of anesthetic agents of the other sympathetic nerves, see 64508–64530. A certificate of medical necessity may be required by some payers. In addition, note that payers may limit the number of injections for which payment will be made during a specified time frame (i.e., three injections within a 12 month period) and only allow repeated treatment when documentation indicates that there is at least a 50 percent reduction in pain for six to eight weeks. Contact the payer for specific guidelines.

Terms To Know

INJ. Injection.

Injection. Forcing a liquid substance into a body part such as a joint or muscle.

sphenopalatine ganglion. Parasympathetic group of nerve cell bodies through which sensory and sympathetic nerves pass, originating from the facial nerve and supplying the nasal, lacrimal, and palatine glands. Synonym(s): Meckel's ganglion, pterygopalatine ganglion, sphenomaxillary ganglion.

turbinates. Scroll or shell-shaped elevations from the wall of the nasal cavity, the inferior turbinate being a separate bone, while the superior and middle turbinates are of the ethmoid bone. Synonym(s): conchae.

ICD-9-CM Diagnostic Codes

350.2 Atypical face pain
524.62 Arthralgia of temporomandibular joint
784.0 Headache
830.1 Open dislocation of jaw
848.1 Sprain and strain of jaw

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

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Explanation
The physician injects the carotid sinus nerve with an anesthetic agent to block sympathetically mediated pain or cardiovascular responses.

Coding Tips
This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59. Local anesthesia is included in these services. Fluoroscopic guidance is reported separately. This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For injections of anesthetic agents of the other sympathetic nerves, see 64505, and 64510–64530. A certificate of medical necessity may be required by some payers. In addition, note that payers may limit the number of injections for which payment will be made during a specified time frame (i.e., three injections within a 12-month period) and only allow repeated treatment when documentation indicates that there is at least a 50 percent reduction in pain for six to eight weeks. Contact the payer for specific guidelines.

Terms To Know

carotid sinus syndrome. Stimulation of an overactive carotid sinus, causing a marked drop in blood pressure, which, in turn, may stop the heart.
injection. Forcing a liquid substance into a body part such as a joint or muscle.
separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

ICD-9-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>333.0</td>
<td>Other degenerative diseases of the basal ganglia</td>
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<tr>
<td>337.00</td>
<td>Idiopathic peripheral autonomic neuropathy, unspecified</td>
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<tr>
<td>337.01</td>
<td>Carotid sinus syndrome</td>
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<tr>
<td>337.09</td>
<td>Other idiopathic peripheral autonomic neuropathy</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.
64510

**Explanation**
The physician performs a nerve block on the stellate ganglion, (also known as the cervicothoracic ganglion) by injecting an anesthetic agent to block sympathetically mediated pain. The stellate ganglion is located at the C7/T1 level vertebrae; its fibers distribute to the head, neck, heart, and upper limb. This block is used to provide anesthetic relief for pain in the face, neck, and upper extremity. Using fluoroscopic imaging, the physician guides the needle into correct placement in the ganglion and injects the nerve block agent. Imaging guidance may be considered an included service by CMS and other payers.

**Coding Tips**
Local anesthesia is included in these services. Fluoroscopic guidance is reported separately. This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image).

For injections of anesthetic agents of the other sympathetic nerves, see 64505–64508 and 64517–64530. A certificate of medical necessity may be required by some payers. In addition, note that payers may limit the number of injections for which payment will be made during a specified time frame (i.e., three injections within a 12-month period) and only allow repeated treatment when documentation indicates that there is at least a 50 percent reduction in pain for six to eight weeks. Contact the payer for specific guidelines.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>337.00</td>
<td>Idiopathic peripheral autonomic neuropathy, unspecified</td>
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<td>Other idiopathic peripheral autonomic neuropathy</td>
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<td>Reflex sympathetic dystrophy of the upper limb</td>
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<td>337.29</td>
<td>Reflex sympathetic dystrophy of other specified site</td>
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<td>338.12</td>
<td>Acute post-thoracotomy pain — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<td>338.18</td>
<td>Other acute postoperative pain — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<td>Other chronic pain — (Use additional code to identify pain associated with psychological factors: 307.89)</td>
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<tr>
<td>353.6</td>
<td>Phantom limb (syndrome)</td>
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<tr>
<td>354.4</td>
<td>Causalgia of upper limb</td>
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<tr>
<td>354.5</td>
<td>Mononeuropathy multiplex</td>
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<td>354.9</td>
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<td>Mononeuropathy of unspecified site</td>
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<td>719.45</td>
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<td>719.46</td>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Injection, anesthetic agent; superior hypogastric plexus

Explanation
The physician performs a nerve block on the superior hypogastric plexus by injecting an anesthetic agent through a needle inserted in the L5/S1 interspace. The superior hypogastric plexus, also called the presacral nerve, is located in front of the upper part of the sacrum and is formed by lower lumbar nerves responsible for pain sensation in the pelvic area. This nerve block is done in such cases as severe, intractable menstrual pain and pain due to pelvic area metastases from cancer such as prostatic malignancy. The patient is placed in the prone position and prepped. A 6-inch needle is guided under radiological imaging, such as fluoroscopy (reported separately), into the ventral lateral spine and through the L5/S1 interspace. Needle position is checked by injecting contrast material and aspirating for the return of any blood, urine, or cerebral spinal fluid. With negative aspiration results and imaging verifying that the needle position is in the prevertebral space and not within a blood vessel, a ureter, or spinal nerves, local anesthetic is injected on both sides.

Coding Tips
For injections of anesthetic agents of the other sympathetic nerves, see 64505–64530. Fluoroscopic guidance is reported separately. For injections of anesthetic agents of the other sympathetic nerves, see 64508–64530. A Certificate of Medical Necessity may be required by some payers. In addition, note that payers may limit the number of injections for which payment will be made during a specified time frame (i.e., three injections within a 12 month period) and only allow repeated treatment when documentation indicates that there is at least a 50 percent reduction in pain for 6-8 weeks. Contact the payer for their specific guidelines. To report acupuncture or blunt needling of the stellate ganglion see 97810-97811 or 97813-97814. To report facet joint injections see 64490-64495. Paravertebral sympathetic injection (lumbar or thoracic) is reported using 64520.

Terms To Know
injection. Forcing a liquid substance into a body part such as a joint or muscle.

ICD-9-CM Diagnostic Codes
353.6 Phantom limb (syndrome)
354.5 Mononeuritis multiplex
355.8 Unspecified mononeuritis of lower limb
355.9 Mononeuritis of unspecified site
443.0 Raynaud's syndrome — (Use additional code to identify gangrene: 785.4)
443.9 Unspecified peripheral vascular disease
617.0 Endometriosis of uterus
617.1 Endometriosis of ovary
617.2 Endometriosis of fallopian tube
617.3 Endometriosis of pelvic peritoneum
617.4 Endometriosis of rectovaginal septum and vagina

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64520

**Explanation**
The physician performs a nerve block on lumbar or thoracic paravertebral sympathetic nerves by injecting an anesthetic agent to block sympathetically mediated pain. The lumbar or thoracic block provides anesthetic relief for pain in the torso, pelvis, and lower extremities. Using fluoroscopic imaging, the physician guides the needle into correct placement into the paravertebral sympathetic nerve fibers and injects the nerve block agent. Imaging guidance may be considered an included service by CMS and other payers.

**Coding Tips**
For injection, anesthetic agent stellate ganglion (cervical sympathetic), see 64510. For destruction by a neurolytic agent, see 64633–64636. Local anesthesia is included in these services. Fluoroscopic guidance is reported separately. For injections of anesthetic agents of the other sympathetic nerves, see 64505–64517, and 64530. A certificate of medical necessity may be required by some payers. In addition, note that payers may limit the number of injections for which payment will be made during a specified time frame (i.e., three injections within a 12-month period) and only allow repeated treatment when documentation indicates that there is at least a 50 percent reduction in pain for six to eight weeks. Contact the payer for specific guidelines.

**ICD-9-CM Diagnostic Codes**
- 337.00 Idiopathic peripheral autonomic neuropathy, unspecified
- 337.09 Other idiopathic peripheral autonomic neuropathy
- 337.22 Reflex sympathetic dystrophy of the lower limb
- 337.29 Reflex sympathetic dystrophy of other specified site
- 338.11 Acute pain due to trauma — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.12 Acute post-thoracotomy pain — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.18 Other acute postoperative pain — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.19 Other acute pain — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.21 Chronic pain due to trauma — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.22 Chronic post-thoracotomy pain — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.28 Other chronic postoperative pain — (Use additional code to identify pain associated with psychological factors: 307.89)
- 338.29 Other chronic pain — (Use additional code to identify pain associated with psychological factors: 307.89)
- 350.1 Trigeminal neuralgia
- 350.8 Other specified trigeminal nerve disorders
- 350.9 Unspecified trigeminal nerve disorder
- 353.6 Phantom limb (syndrome)
- 354.5 Mononeuritis multiplex
- 355.8 Unspecified mononeuropathy of lower limb
- 355.9 Mononeuropathy of unspecified site
- 443.0 Raynaud's syndrome — (Use additional code to identify gangrene: 785.4)
- 443.9 Unspecified peripheral vascular disease
- 617.0 Endometriosis of uterus
- 617.1 Endometriosis of ovary
- 617.2 Endometriosis of fallopian tube
- 617.3 Endometriosis of pelvic peritoneum
- 617.4 Endometriosis of rectovaginal septum and vagina
- 617.5 Endometriosis of intestine
- 617.7 Endometriosis of other specified sites
- 617.9 Endometriosis, site unspecified
- 625.0 Dyspareunia
- 625.2 Mittelschmerz
- 625.3 Dysmenorrhea
- 723.1 Cervicalgia
- 723.2 Cervicocranial syndrome
- 723.3 Cervicobrachial syndrome (diffuse)
- 723.4 Brachial neuritis or radiculitis NOS
- 724.2 Lumbago
- 729.2 Unspecified neuralgia, neuritis, and radiculitis
- 729.5 Pain in soft tissues of limb

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<th>Procedure Codes</th>
<th>Coding and Payment Guide for Anesthesia Services</th>
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<td>Work Value</td>
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64530

64530 Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring

Explanation
The physician injects the celiac plexus with an anesthetic to block sympathetically mediated or visceral pain. Anesthesia is provided with or without radiologic monitoring.

Coding Tips
For destruction celiac plexus by neurolytic agent, see 64680. Local anesthesia is included in these services. Fluoroscopic guidance is reported separately. To report transectoscopic transmural injection performed with ultrasound guidance, see 43253. A certificate of medical necessity may be required by some payers. In addition, note that payers may limit the number of injections for which payment will be made during a specified time frame (i.e., three injections within a 12-month period) and only allow repeated treatment when documentation indicates that there is at least a 50 percent reduction in pain for six to eight weeks. Contact the payer for specific guidelines.

Terms To Know

celiac plexus. 1) Cluster of nerve ganglions functioning as the largest autonomic nerve center in the abdomen, controlling activities such as intestinal contraction and adrenal secretion. 2) Located at the origin of the celiac trunk, the superior mesenteric and renal arteries on either side and front of the aorta.

Synonym(s): solar plexus.

injection. Forcing a liquid substance into a body part such as a joint or muscle.

ICD-9-CM Diagnostic Codes
157.0 Malignant neoplasm of head of pancreas
157.1 Malignant neoplasm of body of pancreas
157.2 Malignant neoplasm of tail of pancreas
157.3 Malignant neoplasm of pancreatic duct
157.4 Malignant neoplasm of islets of Langerhans — (Use additional code to identify any functional activity)
157.8 Malignant neoplasm of other specified sites of pancreas
157.9 Malignant neoplasm of pancreas, part unspecified
577.0 Acute pancreatitis
577.1 Chronic pancreatitis
786.51 Precordial pain
789.00 Abdominal pain, unspecified site
789.01 Abdominal pain, right upper quadrant
789.02 Abdominal pain, left upper quadrant
789.06 Abdominal pain, epigastric
789.07 Abdominal pain, generalized
789.09 Abdominal pain, other specified site

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
64550

Explanation
A transcutaneous neurostimulator is applied to the patient. The provider places electrode pads over the area to be stimulated and connects a transmitter box to the electrodes (e.g., TENS unit). Current is transmitted through the skin to sensory fibers which helps decrease the pain sensation along the nerve distribution.

Coding Tips
This procedure reports transcutaneous placement of a surface neurostimulator only. Incision and percutaneous placement of a neurostimulator pulse generator or receiver is reported separately. For revision or removal of peripheral neurostimulator electrodes, see code 64585. For incisional implantation of neurostimulator electrodes, see codes 64575-64580.

Terms To Know
electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.

TENS. Transcutaneous electrical nerve stimulator. TENS is applied by placing electrode pads over the area to be stimulated and connecting the electrodes to a transmitter box, which sends a current through the skin to sensory nerve fibers to help decrease pain in that nerve distribution.

ICD-9-CM Diagnostic Codes
354.4 Causalgia of upper limb
719.46 Pain in joint, lower leg
722.11 Displacement of thoracic intervertebral disc without myelopathy
723.1 Cervicalgia
723.4 Brachial neuritis or radiculitis NOS
724.2 Lumbago
724.3 Sciatica
729.1 Unspecified myalgia and myositis
729.2 Unspecified neuralgia, neuritis, and radiculitis
846.0 Sprain and strain of lumbosacral (joint) (ligament)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-3,10.2; 100-4,5,10.2

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</table>
64553-64565

6453  Percutaneous implantation of neurostimulator electrode array; cranial nerve
6455  peripheral nerve (excludes sacral nerve)
6456  sacral nerve (transforaminal placement) including image guidance, if performed
64565  neuromuscular

Explanation
The physician places an electrode array percutaneously (through the skin) an introducer needle into the tissue to be stimulated. Electrodes placed over sensory nerves decrease pain sensation in the distribution of the nerve. Electrodes placed over motor nerves stimulate paralyzed muscles to prevent atrophy. In 64553, the electrodes are placed over the motor or sensory points of cranial nerves. In 64555, the electrodes are placed over peripheral motor or sensory nerves, excluding sacral nerves. Report 64561 when stimulators are placed near sacral nerves (via transforaminal approach) that may require imaging guidance. In 64565, the electrodes are placed at the neuromuscular junction to stimulate a specific area of muscle tissue.

Coding Tips
The image guidance is included in 64561 and should not be separately reported. These procedures report percutaneous placement of neurostimulator electrodes only. Incision and subcutaneous placement of a neurostimulator pulse generator or receiver is reported separately. For open placement of a cranial neurostimulator pulse generator or receiver, see 61885-61886. For open placement of a peripheral neurostimulator pulse generator, see 64590. For revision or removal of a cranial nerve neurostimulator pulse generator or receiver, see 61888. For revision or removal of an intracranial neurostimulator electrodes, see 61880. For revision or removal of peripheral neurostimulator electrodes, see 64585. For incisional implantation of neurostimulator electrodes, see 64575-64580. For implantation of trial or permanent electrode arrays or pulse generators for peripheral subcutaneous field stimulation, see 0282T-0284T.

Terms To Know
autonomic nervous system. Portion of the nervous system that controls involuntary body functions. The fibers of the autonomic nervous system regulate the iris of the eye and the smooth-muscle action of the heart, blood vessels, lungs, glands, stomach, colon, bladder, and other visceral organs that are not under conscious control by the individual. The autonomic nerve fibers exit from the central nervous system and branch out into the sympathetic and parasympathetic nervous systems.
cranial nerve. Twelve paired bundles of nerves connected to the brain that control ocular, auditory, and nasal senses; facial muscles; and oral and throat muscles.
electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.

ICD-9-CM Diagnostic Codes
345.41  Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy
345.51  Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-3, 160.12; 100-3, 160.18; 100-4, 32, 40; 100-4, 32, 40.1

CCI Version 20.0
Also not with 64555: 61850
Also not with 64553: 63685, 64561
Also not with 64553: 64575, 64580-64581
Also not with 64555: 61850, 61860, 61870-61880, 63685, 64561, 64575, 64580-64581
Also not with 64555: 61850, 61860, 61870-61886, 64553, 64561, 64566, 64575, 64580-64581, 76000-76001, 77001-77002
Also not with 64561: 64581, 76000-76001, 77001-77003, A4290
Also not with 64555: 61850, 61860, 61870-61886, 64553-64555, 64561, 64575, 64580-64585
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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64600-64610

64600  Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605  second and third division branches at foramen ovale
64610  second and third division branches at foramen ovale under radiologic monitoring

Explanation
The physician destroys a portion of the trigeminal nerve to block pain or motor control to the face or scalp. Destruction is accomplished by injecting the nerve with alcohol or phenol. In 64600, a supraorbital, infraorbital, mental, or inferior alveolar branch of the trigeminal nerve is destroyed. In 64605, the second and third division branches at the foramen ovale are destroyed. Report 64610 if the second and third division branches at the foramen ovale are destroyed under radiologic monitoring.

Coding Tips
Therapeutic and diagnostic injections performed during the same session are not reported separately. When reporting destruction therapies that are not specific to a target nerve, such as pulse radiofrequency, code 64999 should be identified on the claim. The chemodenervation agent and/or therapeutic agent is reported separately using the appropriate HCPCS Level II code.

Terms To Know
intra. Within.
neurolytic. Destruction of nerve tissue.
orbital. Pertaining to the orbit (bony cavity containing the eyeball).
supra. Above.

ICD-9-CM Diagnostic Codes
171.0  Malignant neoplasm of connective and other soft tissue of head, face, and neck
225.1  Benign neoplasm of cranial nerves
238.1  Neoplasm of uncertain behavior of connective and other soft tissue
239.2  Neoplasms of unspecified nature of bone, soft tissue, and skin
350.1  Trigeminal neuralgia
350.2  Atypical face pain
350.8  Other specified trigeminal nerve disorders
907.1  Late effect of injury to cranial nerve
951.2  Injury to trigeminal nerve

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0
Also not with 64600: J2001
Also not with 64605: J2001
Also not with 64610: 64605
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

**Explanation**
The practitioner administers a neurotoxin to paralyze dysfunctional muscle tissue, bilaterally, that is innervated by the facial, trigeminal, cervical spinal, and accessory nerves. Chemodenervation works by introducing a substance used to block the transfer of chemicals at the presynaptic membrane. Botulinum toxin type A (BTX-A, Botox®), phenol (sometimes combined with botulinum toxin type A), and/or ethyl alcohol may be used. The practitioner identifies the nerve(s) or muscle endplate(s) by direct surgical exposure or through the insertion of an electromyographic needle into the muscle. A small amount of the selected agent is injected into nerve(s) or muscle endplate(s), inducing muscle paralysis. Gradually, blocked nerves form new neuromuscular junctions resulting in the return of muscle function. The duration of the effect is variable, usually one to 12 months when phenol or alcohol is used, and three to four months when BTX-A is used. BTX-A is dose-dependent and reversible secondary to the regeneration process.

**Coding Tips**
Code 64615 refers to the entire destruction procedure and is reported only once even though more than one injection may be required to complete the procedure. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II codes. Check with the specific payer to determine coverage. To report guidance procedures, see codes 95873 and 95874. A single guidance should be reported in conjunction with this procedure. Do not report this procedure in addition to other muscle chemodenervation procedures (64612, 61616–64617) or other chemodenervation codes 64642–64647).

**Terms To Know**
chemodenervation. Chemical destruction of nerves.

**ICD-9-CM Diagnostic Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>333.3</td>
<td>Tics of organic origin — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>333.6</td>
<td>Genetic torsion dystonia</td>
</tr>
<tr>
<td>333.79</td>
<td>Other acquired torsion dystonia</td>
</tr>
<tr>
<td>333.81</td>
<td>Blepharospasm — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>333.82</td>
<td>Orofacial dyskinesia — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>333.83</td>
<td>Spasmodic torticollis — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>333.89</td>
<td>Other fragments of torsion dystonia — (Use additional E code to identify drug, if drug-induced)</td>
</tr>
<tr>
<td>340</td>
<td>Multiple sclerosis</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>350.2</td>
<td>Atypical face pain</td>
</tr>
<tr>
<td>351.8</td>
<td>Other facial nerve disorders</td>
</tr>
<tr>
<td>478.79</td>
<td>Other diseases of larynx — (Use additional code to identify infectious organism)</td>
</tr>
</tbody>
</table>

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)

Explanation
The physician administers a neurotoxin to paralyze dysfunctional muscle tissue of the neck. Chemodenervation works by introducing a substance used to block the transfer of chemicals at the presynaptic membrane. Botulinum toxin type A (BTX-A, Botox®), phenol (sometimes combined with botulinum toxin type A), and/or ethyl alcohol may be used. The physician identifies the nerve(s) or muscle endplate(s) by direct surgical exposure or through the insertion of an electromyographic needle into the muscle. A small amount of the selected agent is injected into nerve(s) or muscle endplate(s), inducing muscle paralysis. The duration of the effect is variable, usually one to 12 months when phenol or alcohol is used and three to four months when BTX-A is used. BTX-A is dose-dependent and reversible secondary to the regeneration process. Gradually, blocked nerves form new neuromuscular junctions resulting in the return of muscle function.

Coding Tips
This code is new for 2014. It is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Only one guidance code should be reported for each chemodenervation unit reported. This code should not be reported with codes 95873 or 95874. When the chemodenervation of the larynx is performed under direct visualization (laryngoscopy) report the appropriate code from 31570–31571. Diagnostic electromyography of the larynx is reported with 95865.

Terms To Know
chemodenervation. Chemical destruction of nerves.

ICD-9-CM Diagnostic Codes
333.3 Tic of organic origin — (Use additional E code to identify drug, if drug-induced)
333.6 Genetic torsion dystonia
333.79 Other acquired torsion dystonia
333.81 Blepharospasm — (Use additional E code to identify drug, if drug-induced)
333.82 Orofacial dyskinesia — (Use additional E code to identify drug, if drug-induced)
333.83 Spasmodic torticollis — (Use additional E code to identify drug, if drug-induced)
333.89 Other fragments of torsion dystonia — (Use additional E code to identify drug, if drug-induced)
340 Multiple sclerosis

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64617

Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed

Explanation
The physician administers a neurotoxin to paralyze the larynx. Chemodenervation works by introducing a substance used to block the transfer of chemicals at the presynaptic membrane. Botulinum toxin type A (BTX-A, Botox®), phenol (sometimes combined with botulinum toxin type A), and/or ethyl alcohol may be used. The injection site is identified by the insertion of an electromyographic needle into the muscle tissue near the larynx. A small amount of the selected agent is injected into nerve(s) or muscle(s) around the larynx. The duration of the effect is variable, usually one to 12 months when phenol or alcohol is used and three to four months when BTX-A is used. BTX-A is dose-dependent and reversible secondary to the regeneration process. Gradually, blocked nerves form new neuromuscular junctions resulting in the return of muscle function.

Coding Tips
This code is new for 2014. It is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Only one guidance code should be reported for each chemodenervation unit reported. This code should not be reported with codes 95873 or 95874. When the chemodenervation of the larynx is performed under direct visualization (laryngoscopy), report the appropriate code from 31570–31571. Diagnostic electromyography of the larynx is reported with 95865.

Terms To Know
Chemodenervation. Chemical destruction of nerves.

ICD-9-CM Diagnostic Codes

333.3 Tics of organic origin — (Use additional E code to identify drug, if drug-induced)
333.6 Genetic torsion dystonia
333.79 Other acquired torsion dystonia
333.81 Blepharospasm — (Use additional E code to identify drug, if drug-induced)
333.82 Orofacial dyskinesia — (Use additional E code to identify drug, if drug-induced)
333.83 Spasmodic torticollis — (Use additional E code to identify drug, if drug-induced)
333.89 Other fragments of torsion dystonia — (Use additional E code to identify drug, if drug-induced)
340 Multiple sclerosis
350.2 Atypical face pain

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Destruction by neurolytic agent, intercostal nerve

**Explanation**
This procedure is performed to treat chronic chest pain commonly associated with pleurisy, acute herpes zoster, and post herpetic neuralgia. An intercostal nerve is destroyed using chemical, thermal, electrical, or radiofrequency techniques, which may be used independently or in combination. This procedure is designed to destroy the specific site(s) in the nerve root that produces the pain while leaving sensation intact. Generally intravenous conscious sedation is used during the initial phase of the procedure so that the patient can assist the physician in identifying the site of pain and the correct placement of the neurolytic agent, and local anesthesia is administered during the destruction phase of the procedure. Using separately reportable fluoroscopic guidance, a needle is inserted into the affected nerve root. An electrode is inserted through the needle and a mild electrical current is passed through the electrode. The current produces a tingling sensation at a site on the nerve. The electrode is manipulated until the tingling sensation is felt at the same site as the pain. Once the physician has determined that the electrode is positioned at the site responsible for the pain, a local anesthetic is administered and a neurolytic agent applied. Chemical destruction involves injection of a neurolytic substance (e.g., alcohol, phenol, glycerol) into the affected nerve root. Thermal techniques use heat. Electrical techniques use an electrical current. Radiofrequency, also referred to as radiofrequency rhizotomy, uses a solar or microwave current.

**Coding Tips**
For fluoroscopic guidance and localization for needle placement and neurolysis in conjunction with code 64620, see code 77003. Therapeutic and diagnostic injections performed during the same session are not reported separately. When reporting destruction therapies that are not specific to a target nerve, such as pulse radiofrequency, code 64999 should be identified on the claim. The chemodenervation agent and/or therapeutic agent is reported separately using the appropriate HCPCS Level II code.

**Terms To Know**
- **fluoroscopy.** Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
- **intravenous.** Within a vein or veins.
- **moderate sedation.** Medically controlled state of depressed consciousness, with or without analgesia, while maintaining the patient’s airway, protective reflexes, and ability to respond to stimulation or verbal commands.
- **neurolytic.** Destruction of nerve tissue.
- **radiofrequency ablation.** To destroy by electromagnetic wave frequencies.

**ICD-9-CM Diagnostic Codes**
- 355.9 Mononeuritis of unspecified site
- 729.2 Unspecified neuralgia, neuritis, and radiculitis
- 786.52 Painful respiration

**CCI Version 20.0**

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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64630-64640
64630 Destruction by neurolytic agent; pudendal nerve
64632 plantar common digital nerve
64640 other peripheral nerve or branch

Explanation
These procedures are performed to treat chronic pain. The affected nerve is destroyed using chemical, thermal, electrical, or radiofrequency techniques, which may be used independently or in combination. This procedure is designed to destroy the specific site(s) in the nerve root that produces the pain while leaving sensation intact. Generally intravenous conscious sedation is used during the initial phase of the procedure so that the patient can assist the physician in identifying the site of pain and the correct placement of the neurolytic agent, and local anesthesia is administered during the destruction phase of the procedure. Using separately reportable fluoroscopic or CT guidance, a needle is inserted next to the ischial spine, contrast dye is injected, and the nerve canal anatomy is confirmed. An electrode is inserted through the needle and a mild electrical current is passed through the electrode. The current produces a tingling sensation at a site on the nerve. The electrode is manipulated until the tingling sensation is felt at the same site as the pain. Once the physician has determined that the electrode is positioned at the site responsible for the pain, a local anesthetic is administered and a neurolytic agent applied. Chemical destruction involves injection of a neurolytic substance (e.g., alcohol, phenol, glycerol) into the affected nerve root. Thermal techniques use heat. Electrical techniques use an electrical current. Radiofrequency, also referred to as radiofrequency rhizotomy, uses a solar or microwave current. Report 64630 for destruction of the pudendal nerve, which is referred to as radiofrequency rhizotomy, uses a solar or microwave current. Report 64632 when performed to treat chronic pain of the external genitalia, pelvis, and anorectal region. Report 64632 when performed to treat chronic pain that originates in a peripheral nerve other than the intercostal, pudendal, plantar, or spinal nerve(s).

Coding Tips
Code 64632 should not be reported in conjunction with 64455. Therapeutic and diagnostic injections performed during the same session are not reported separately. When reporting destruction therapies that are not specific to a target nerve, such as pulse radiofrequency, code 64999 should be identified on the claim. The chemodenervation agent and/or therapeutic agent is reported separately using the appropriate HCPCS Level II code.

Terms To Know
injection. Forcing a liquid substance into a body part such as a joint or muscle. intravenous. Within a vein or veins. neurolytic. Destruction of nerve tissue.

rhizotomy. Procedure to interrupt the roots of cranial or spinal nerves. Posterior rhizotomy separates the sensory spinal nerve roots to relieve intractable pain. Anterior rhizotomy separates the motor spinal nerve roots to stop involuntary spasmodic movements associated with conditions like cerebral palsy, torticollis, or paraplegia. Trigeminal rhizotomy destroys part of the fifth cranial nerve sensory root or ganglion to relieve trigeminal neuralgia.

ICD-9-CM Diagnostic Codes
154.0 Malignant neoplasm of rectosigmoid junction
154.1 Malignant neoplasm of rectum
154.8 Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
180.0 Malignant neoplasm of endocervix
180.1 Malignant neoplasm of exocervix
180.9 Malignant neoplasm of cervix uteri, unspecified site
184.0 Malignant neoplasm of vagina
184.1 Malignant neoplasm of labia majora
184.2 Malignant neoplasm of labia minora
184.4 Malignant neoplasm of vulva, unspecified site
185 Malignant neoplasm of prostate
197.5 Secondary malignant neoplasm of large intestine and rectum
198.82 Secondary malignant neoplasm of genital organs
729.2 Unspecified neuralgia, neuritis, and radiculitis

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0
Also not with 6432: 64445-64455, J0670
Also not with 6440: 64445-64455, 64632

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

<table>
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<th>Base Unit</th>
<th>Work Value</th>
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<td>1.34</td>
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</table>
performed during the same session are not reported separately. When procedures, report 64999. Therapeutic and diagnostic injections or 77012. If CT or fluoroscopic imaging is not used with these components of 64633–64634. Do not report 64633–64634 with 77003 (mirror image). Imaging guidance and injection of contrast are inclusive procedure performed identically on the opposite side of the body appended. Check with individual payers. Modifier 50 identifies a others require identification of the service only once with modifier 50 procedure is performed bilaterally, some payers require that the service date of service as the primary service or procedure and must never be reimbursed on codes listed above. The chemodenervation agent and/or therapeutic agent is reported separately using the appropriate HCPCS Level II code.

**ICD-9-CM Diagnostic Codes**

- **720.1** Spinal enthesopathy
- **721.0** Cervical spondylosis without myelopathy
- **721.2** Thoracic spondylosis without myelopathy
- **721.41** Spondylosis with myelopathy, thoracic region
- **721.90** Spondylosis of unspecified site without mention of myelopathy
- **722.11** Displacement of thoracic intervertebral disc without myelopathy
- **722.4** Degeneration of cervical intervertebral disc
- **722.51** Degeneration of thoracic or thoracolumbar intervertebral disc
- **722.71** Intervertebral cervical disc disorder with myelopathy, cervical region
- **722.72** Intervertebral thoracic disc disorder with myelopathy, cervical region
- **722.81** Postlaminectomy syndrome, cervical region
- **722.82** Postlaminectomy syndrome, thoracic region
- **723.1** Cervicalgia
- **724.00** Spinal stenosis, unspecified region other than cervical
- **724.01** Spinal stenosis of thoracic region
- **724.09** Spinal stenosis, other region other than cervical
- **724.1** Pain in thoracic spine
- **733.13** Pathologic fracture of vertebrae
- **738.4** Acquired spondylolisthesis

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**

- Also not with 64634: 77002-77003

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**ICD-9-CM Diagnostic Codes**

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<th>Code</th>
<th>Condition</th>
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<td>720.1</td>
<td>Spinal enthesopathy</td>
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<tr>
<td>721.3</td>
<td>Lumbosacral spondylodyplasia without myelopathy</td>
</tr>
<tr>
<td>721.42</td>
<td>Spondylosis with myelopathy, lumbar region</td>
</tr>
<tr>
<td>721.90</td>
<td>Spondylosis of unspecified site without mention of myelopathy</td>
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<tr>
<td>722.10</td>
<td>Displacement of lumbar intervertebral disc without myelopathy</td>
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<tr>
<td>722.51</td>
<td>Degeneration of thoracic or thoracolumbar intervertebral disc</td>
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<td>722.52</td>
<td>Degeneration of lumbar or lumbosacral intervertebral disc</td>
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<tr>
<td>722.73</td>
<td>Intervertebral lumbar disc disorder with myelopathy, lumbar region</td>
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<td>722.83</td>
<td>Postlaminectomy syndrome, lumbar region</td>
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<td>Spinal stenosis, unspecified region other than cervical</td>
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<td>724.02</td>
<td>Spinal stenosis of lumbar region, without neurogenic claudication</td>
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<td>Spinal stenosis of lumbar region, with neurogenic claudication</td>
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<td>Spinal stenosis, other region other than cervical</td>
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<td>Pathologic fracture of vertebrae</td>
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<td>738.4</td>
<td>Acquired spondylolisthesis</td>
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Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

### Coding Tips

These are resequenced codes and will not display in numeric order. As an add-on code, 64635 is not subject to multiple procedure rules. No reimbursement reduction or modifier S1 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service or procedure and must never be reported as stand-alone codes. This is a unilateral procedure. If the procedure is performed bilaterally, some payers require that the service be reported twice with modifier S0 appended to the second code while others require identification of the service only once with modifier S0 appended. Check with individual payers. Modifier S0 identifies a procedure performed identically on the opposite side of the body (mirror image). Imaging guidance and injection of contrast are inclusive components of 64635–64636. Do not report 64635–64636 with 77003 or 77012. If CT or fluoroscopic imaging is not used with these procedures, report 64999.

### CCI Version 20.0

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64642-64645

64642  Chemodenervation of one extremity; 1-4 muscle(s)
64643  each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)
64644  Chemodenervation of one extremity; 5 or more muscles
64645  each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)

Explanation
The physician administers a neurotoxin to paralyze dysfunctional muscle tissue in the extremities. Chemodenervation works by introducing a substance used to block the transfer of chemicals at the presynaptic membrane. Botulinum toxin type A (BTX-A, Botox®), phenol (sometimes combined with botulinum toxin type A), and/or ethyl alcohol may be used. The physician identifies the nerve(s) or muscle endplate(s) by direct surgical exposure or through the insertion of an electromyographic needle into the muscle. A small amount of the selected agent is injected into nerve(s) or muscle endplate(s), inducing muscle paralysis. The duration of the effect is variable, usually one to 12 months when phenol or alcohol is used and three to four months when BTX-A is used. BTX-A is dose-dependent and reversible secondary to the regeneration process. Gradually, blocked nerves form new neuromuscular junctions resulting in the return of muscle function. Report 64642 when the procedure is performed on one to four muscles of a single extremity and 64643 for one to four muscles of each additional extremity. Report 64644 when five or more muscles are treated in a single extremity and 64645 for five or more muscles of each additional extremity.

Coding Tips
These codes are new for 2014. Report 64642 and 64644 only once per encounter; additional extremities are reported with 64643 and 64645 when performed. When reported together, these codes may total up to four units (indicating all four extremities). Codes 64643 and 64645 are add-on codes are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service or procedure, and must never be reported as stand-alone codes. Report code 64643 once for additional extremity when one to four muscles are treated in addition to codes 64642 or 64644. When five or more muscles are treated in an additional extremity, report 64645 in addition to code 64644. To report chemodenervation of the trunk muscles, see 64646-64647.

Terms To Know
chemodenervation. Chemical destruction of nerves.

ICD-9-CM Diagnostic Codes
333.6  Genetic torsion dystonia
333.79  Other acquired torsion dystonia

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<td>Procedure Codes</td>
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Chemodenervation of trunk muscle(s); 1-5 muscle(s)

Explanation
The physician administers a neurotoxin to paralyze dysfunctional muscle tissue in the trunk, including the erector spinae, rectus abdominis, oblique, and paraspinal muscles. Chemodenervation works by introducing a substance used to block the transfer of chemicals at the presynaptic membrane. Botulinum toxin type A (BTX-A, Botox®), phenol (sometimes combined with botulinum toxin type A), and/or ethyl alcohol may be used. The physician identifies the nerve(s) or muscle endplate(s) by direct surgical exposure or through the insertion of an electromyographic needle into the muscle. A small amount of the selected agent is injected into nerve(s) or muscle endplate(s), inducing muscle paralysis. The duration of the effect is variable, usually one to 12 months when phenol or alcohol is used and three to four months when BTX-A is used. BTX-A is dose-dependent and reversible secondary to the regeneration process. Gradually, blocked nerves form new neuromuscular junctions resulting in the return of muscle function. Report 64646 when one to five muscles are treated and 64647 when six or more muscles are treated.

Coding Tips
These codes are new for 2014. Correct code selection is dependent upon the number of muscles treated. Report 64646 for one to five muscles, 64647 for six or more muscles. Muscle of the trunk include the erector spinae and the paraspinal muscles as well as the abdominis and oblique muscles. Report 64646 or 64647 only once per encounter. Do not report these codes together for the same encounter. For electrical stimulation or needle electromyography guidance with chemodenervation, see 95873–95874.

Terms To Know
chemodenervation. Chemical destruction of nerves.

ICD-9-CM Diagnostic Codes
333.6 Genetic torsion dystonia
333.79 Other acquired torsion dystonia
338.11 Acute pain due to trauma — (Use additional code to identify pain associated with psychological factors: 307.89)
338.12 Acute post-thoracotomy pain — (Use additional code to identify pain associated with psychological factors: 307.89)
338.18 Other acute postoperative pain — (Use additional code to identify pain associated with psychological factors: 307.89)
338.19 Other acute pain — (Use additional code to identify pain associated with psychological factors: 307.89)
338.21 Chronic pain due to trauma — (Use additional code to identify pain associated with psychological factors: 307.89)
338.22 Chronic post-thoracotomy pain — (Use additional code to identify pain associated with psychological factors: 307.89)
64680-64681
64680  Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64681  superior hypogastric plexus

Explanation
In 64680, the physician destroys the celiac plexus by applying a neurolytic agent to the celiac plexus. The celiac plexus is a network of nervous tissue that mediates sympathetic pain from the abdomen. This neurolytic block is often performed for pain relief of unresectable cancer in the upper abdomen. The celiac plexus is destroyed usually by chemodenervation, injecting phenol or alcohol to paralyze the network of nervous tissue. This procedure may be performed with or without radiologic monitoring, but is normally performed under CT guidance. In 64681, the physician performs a neurolysis on the superior hypogastric plexus by injecting a chemical, thermal, or electrical agent through a needle inserted in the L5/S1 interspace. The superior hypogastric plexus, also called the presacral nerve, is located in front of the upper part of the sacrum and is formed by lower lumbar nerves responsible for pain sensation in the pelvic area. Nerve destruction is done in such cases as severe, intractable menstrual pain and pain due to pelvic area metastases from cancer such as prostatic malignancy when an anesthetic nerve block does not offer sufficient relief. The patient is placed in the prone position and prepped. A 6-inch needle is guided under radiological imaging, such as fluoroscopy (reported separately), into the ventral lateral spine and through the L5/S1 interspace. Needle position is checked by injecting contrast material and aspirating for the return of any blood, urine, or cerebral spinal fluid. With negative aspiration results and imaging verifying that the needle position is in the prevertebral space and not within a blood vessel, a ureter, or spinal nerves, the neurolytic agent is injected, or delivered, to both sides.

Coding Tips
Therapeutic and diagnostic injections performed during the same session are not reported separately. When reporting destruction therapies that are not specific to a target nerve, such as pulse radiofrequency, code 64999 should be identified on the claim. The chemodenervation agent and/or therapeutic agent are reported separately using the appropriate HCPCS Level II code. When documentation indicates that the provider performed a transcatheter ultrasound-guided transmural injection of neurolytic agent to the celiac plexus, report 43253.

Terms To Know
celiac plexus. 1) Cluster of nerve ganglions functioning as the largest autonomic nerve center in the abdomen, controlling activities such as intestinal contraction and adrenal secretion. 2) Located at the origin of the celiac trunk, the superior mesenteric and renal arteries on either side and front of the aorta.

Syonym(s): solar plexus.

Contrast material. Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomography; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.

Interspace. Space between two similar objects.

neurolytic. Destruction of nerve tissue.

ICD-9-CM Diagnostic Codes
157.0  Malignant neoplasm of head of pancreas
157.1  Malignant neoplasm of body of pancreas
157.2  Malignant neoplasm of tail of pancreas
157.3  Malignant neoplasm of pancreatic duct
157.4  Malignant neoplasm of islets of Langerhans — (Use additional code to identify any functional activity)
577.1  Chronic pancreatitis
577.8  Other specified disease of pancreas

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

CCI Version 20.0
Also not with 64680: 0213T, 62311, 62319, 64400-64413, 64418-64435, 64490, J2001
Also not with 64681: 0216T, 62310-62319, 64400-64435, 64493

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Explanation
A radiologic imaging examination is performed on the veins lining the spinal canal. Contrast is injected into the epidural space under direct fluoroscopy. Examining the flow of contrast in the epidural space around the nerves to be studied aids in the diagnosis of intervertebral disc herniations, narrowing and swelling around the nerve and/or nerve roots, and compressive lesions.

Coding Tips
Code 72275 is reported only when an epidurogram is performed and includes documentation of images and a formal radiologic report. For an injection procedure, see codes 62280–62282, 62310–62319, and 64479–64484. Code 72275 includes any fluoroscopic guidance and localization of needle or catheter tip. Do not report code 77003 in conjunction with 72275. Radiology services are typically performed without anesthesia. In those rare instances where anesthesia is required, report code 01935. This procedure should not be reported in conjunction with pre-sacral interbody technique arthrodesis (22586, 0195T, 0196T or 0309T).

Terms To Know
contrast material. Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomograph; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.
epidural space. Area between the dura mater and the interior surface of the spinal canal, containing fat, veins, and arteries.
fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
interpretation. Professional health care provider's review of data with a written or verbal opinion.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
00600, 00620, 00625-00626, 00630, 01935-01936, 76000-76001, 77001-77003, 99446-99449
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

Explanation
This code reports the fluoroscopic guidance for placement, replacement, or removal of a central venous access device (CVAD) to be used in conjunction with the code for the procedure. For example, a tunneled, centrally inserted CVAD is inserted without subcutaneous port or pump. The site over the access vein (e.g., subclavian, jugular) is injected with local anesthesia and punctured with a needle or accessed by cutdown approach. A guidewire is inserted. A subcutaneous tunnel is created using a blunt pair of forceps or sharp tunneling tools over the clavicle from the anterior chest wall to the venotomy site, which is dilated to the right size. The catheter is passed through this tunnel over the guidewire and into the target vein. Fluoroscopy is used throughout the procedure to guide catheter placement and to check the positioning of the catheter tip. This code includes any contrast injections done through the access site or through the catheter with the necessary corresponding radiological supervision and interpretation of the venography, and the radiographic check of final catheter position.

Coding Tips
As an add-on code, 77001 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Do not report code 77001 in conjunction with 77002.

Terms To Know
- **central venous access device.** Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.
- **cutdown.** Small, incised opening in the skin to expose a blood vessel, especially over a vein (venous cutdown) to allow venipuncture and permit a needle or cannula to be inserted for the withdrawal of blood or administration of fluids.
- **removal.** Process of moving out of or away from, or the fact of being removed.
- **replacement.** Insertion of new tissue or material in place of old one.
- **venography.** Radiographic study of the veins.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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CCI Version 20.0
36005, 36598, 71010, 71020, 75820, 75822, 75825, 75827, 76000-76001, 76942, 76998, 77002, 99446-99449
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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77002

Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

Explanation

Needle biopsy or fine needle aspiration is guided by fluoroscopic visualization. A cutting biopsy or fine needle is inserted into the target area and the position reaffirmed by fluoroscopy. This is done for an internal mass or lesion that has been positively identified by other diagnostic imaging performed earlier.

Coding Tips

Procedure 77002 has both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. This code includes all radiographic arthrography except for the supervision and interpretation of CT and MRA. Do not report 77002 in conjunction with 10030, 19081–19086, 32554–32557, 70332, 73040, 73085, 73115, 73352, 73580, 73615, or 0232T. Code 77002 is considered an integral part of the following radiologic supervision and interpretation codes: 49440, 74320, 74355, 74445, 74470, 74475, 75809, 75810, 75885, 75980, 75982, and 75989. For platelet rich plasma injection, see 0232T. Do not report 22586, 27096, 64479–64484, 64490–64495, 64633–64636, 0195T, 0196T, or 0309T in addition to 77002.

Terms To Know

aspiration. Drawing fluid out by suction.
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
injection. Forcing a liquid substance into a body part such as a joint or muscle.

ICD-9-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0

76000-76001, 76125, 77003, 99446-99449
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)

**Explanation**
Spinal and certain paraspinal diagnostic or therapeutic nerve injection procedures (e.g., epidural or subarachnoid injections) are guided by fluoroscopy before and during catheter or needle insertion. The target structure is localized, the needle is placed and advanced, and the contrast injection is visualized under fluoroscopic monitoring.

**Coding Tips**
Fluoroscopic guidance for subarachnoid puncture for diagnostic myelography is included in 72240–72270. For epidural or subarachnoid needle or catheter placement and injection, see 62270–62282 and 62310–62319. For sacroiliac joint arthrography, see 27096. For paravertebral facet joint nerve injection, see 64490–64495. For paravertebral facet joint nerve destruction by neurolysis, see 64633–64636. For transformaminal epidural needle placement and injection, see 64479–64484. Percutaneous or endoscopic lysis of epidural adhesions is reported with 62263 and 62264 and includes fluoroscopic guidance and localization. Do not report 10030, 27096, 64479–64484, 64490– 64495, or 64633–64636 in addition to 77003. This procedure should not be reported in conjunction with pre-sacral interbody technique arthrodesis (22586, 0195T, 0196T or 0309T), sacroiliac joint injection procedures (27096), nerve block procedures (64479–64484, 64490–64495), and destruction by neurolytic agents procedures (61633–64436). Injection of contrast media during fluoroscopic guidance and localization is included in 22526, 22527, 27096, 62263, 62264, 62267, 62270–62282, and 62310–62319, and should not be reported separately.

**Terms To Know**
catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
epidural. Anesthesia commonly used during labor and delivery achieved by the injection of an anesthetic agent between the vertebrae into the extradural space.
fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.
Injection. Forcing a liquid substance into a body part such as a joint or muscle.
myelogram. Radiological images of the spinal cord after injection of contrast medium.
neurolytic. Destruction of nerve tissue.
subarachnoid. Located below the arachnoid meningeal layer.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.
77012

77012  Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation

Explanation
Computed tomography (CT) is used for guiding needle biopsies. CT scanning directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is able to visualize soft tissue, as well as bones. Patients are required to remain motionless during the study. Once the exact needle entry site is determined, along with the depth of the lesion, the optimal route from the skin to the lesion is decided. The needle is inserted and advanced to the lesion and another CT scan image is done to confirm placement for the biopsy. This code reports the radiological supervision and interpretation only for this procedure.

Coding Tips
Procedure 77012 has both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. For platelet rich plasma injection, see 0232T. Do not report 77012 in conjunction with 10030, 22586, 27096, 32554–32557, 64479–64484, 64490–64495, 64633–64636, 0195T–0196T, 0232T, or 0309T.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.
professional component. Portion of a charge for health care services that represents the physician's (or other practitioner's) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges.
supervision and interpretation. Radiology services that usually contain an invasive component and are reported by the radiologist for supervision of the procedure and the personnel involved with performing the examination, reading the film, and preparing the written report.
technical component. Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services.

Synonym(s): TC

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Explanation
Magnetic resonance is used for guiding needle placement required for procedures such as breast biopsies, needle aspirations, injections, or placing localizing devices. Magnetic resonance imaging (MRI) is a radiation-free, noninvasive technique that produces high-quality images. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electromagnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Some methods for magnetic resonance needle placement include coating the needle with contrast material, placing metallic ringlets along the needle, or using a receiving coil in the tip of the needle. This code reports the radiological supervision and interpretation only for this procedure.

Coding Tips
Procedure 77021 has both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. To report the surgical portion of the procedure, see the appropriate organ or site. Report 77021 for magnetic resonance guidance used in placement of the catheters, devices, or needles. Report the procedure separately, using the appropriate code for the procedure, site, or organ. Do not report with 10030, 19085, 19287, 32554–32557, or 0232T.

Terms To Know
- **aspiration**: Drawing fluid out by suction.
- **biopsy**: Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
- **catheter**: Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
- **injection**: Forcing a liquid substance into a body part such as a joint or muscle.
- **lesion**: Area of damaged tissue that has lost continuity or function, due to disease or trauma.
- **professional component**: Portion of a charge for health care services that represents the physician's (or other practitioner's) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges.
- **supervision and interpretation**: Radiology services that usually contain an invasive component and are reported by the radiologist for supervision of the procedure and the personnel involved with performing the examination, reading the film, and preparing the written report.
- **technical component**: Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services.

### ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

### IOM References
100-3, 220.13

### CCI Version 20.0
01922, 76000-76001, 77001-77003, 77012, 99446-99449

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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92950

**Cardiopulmonary resuscitation (eg, in cardiac arrest)**

**Explanation**
Cardiopulmonary arrest occurs when the patient's heart and lungs suddenly stop. In a clinical setting, cardiopulmonary resuscitation, the attempt at restarting the heart and lungs, is usually directed by a physician or another health care provider who is certified in Advanced Cardiac Life Support (ACLS). The patient's lungs are ventilated by mouth-to-mouth breathing or by a bag and mask. The patient's circulation is assisted using external chest compression. An electronic defibrillator may be used to shock the heart into restarting. Medications used to restart the heart include epinephrine and lidocaine.

**Coding Tips**
This procedure is considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100–01999). For critical care services, see codes 99291–99292.

**Terms To Know**
defibrillation. Arrest of cardiac arrhythmias (atrial or ventricular) with restoration of normal rhythm, usually by applying brief electroshock to the heart. **Synonym(s):** cardioversion.

**ICD-9-CM Diagnostic Codes**
- 427.5 Cardiac arrest
- 518.81 Acute respiratory failure
- 518.84 Acute and chronic respiratory failure
- 779.85 Cardiac arrest of newborn — (Use additional code(s) to further specify condition)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

**CCI Version 20.0**

<table>
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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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94002-94003

94002 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

94003 hospital inpatient/observation, each subsequent day

Explanation
A mechanical ventilator is applied with a mask over the nose and mouth or through a tube placed into the trachea for patients requiring help breathing due to a lung disorder. Intermittent positive pressure breathing uses positive pressure during the inspiration phase of breathing. Code 94002 applies to ventilation assistance using adjustments in volume and pressure on the initial day of treatment in a hospital to an inpatient or observation patient and 94003 is reported for ventilation assistance to a hospital inpatient observation patient provided on subsequent days. Ventilation assistance and management provided to a nursing facility patient is reported with 94004 on a per day basis.

Coding Tips
A physician or other qualified health care provider may bill separately for ventilation management when care plan oversight services (99339, 99340, 99374–99378) are provided by a different provider. Otherwise, ventilation management should not be billed with an evaluation and management service. These procedures are considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100–01999).

ICD-9-CM Diagnostic Codes

518.0 Pulmonary collapse
518.1 Interstitial emphysema
518.2 Compensatory emphysema
518.4 Unspecified acute edema of lung
518.51 Acute respiratory failure following trauma and surgery
518.52 Other pulmonary insufficiency, not elsewhere classified, following trauma and surgery
518.53 Acute and chronic respiratory failure following trauma and surgery
518.81 Acute respiratory failure
518.82 Other pulmonary insufficiency, not elsewhere classified
518.83 Chronic respiratory failure
518.84 Acute and chronic respiratory failure
768.5 Severe birth asphyxia — (Use additional code(s) to further specify condition. Use only when associated with newborn morbidity classifiable elsewhere)
768.6 Mild or moderate birth asphyxia — (Use additional code(s) to further specify condition. Use only when associated with newborn morbidity classifiable elsewhere)
769 Respiratory distress syndrome in newborn — (Use additional code(s) to further specify condition)

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CCI Version 20.0
Also not with 94002: 94003-94004
Also not with 94003: 00520, 94004
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Continuous positive airway pressure ventilation (CPAP), initiation and management

Continuous negative pressure ventilation (CNP), initiation and management

Explanation
A mechanical ventilator is applied with a mask over the nose and mouth or through a tube placed into the trachea for patients requiring help breathing due to a lung disorder. Intermittent positive pressure breathing uses positive pressure during the inspiration phase of breathing. This code applies to initial evaluation or application of continuous positive airway pressure for ventilation assistance with positive pressure during inspiration and exhalation.

Coding Tips
Codes 94660-94662 do not include intubation; report separately when performed, see code 31500. CPAP may be provided by mask or by endotracheal tube with or without a ventilator. It is often used for patients who are still able to breathe spontaneously, but whose respiratory status is so compromised they may need mechanical ventilation if their breathing doesn’t improve. Negative-pressure ventilation provides night-time respiratory muscle rest with patients, for example, with chronic obstructive pulmonary disease (COPD) or neuromuscular diseases such as ALS. This modality is usually not used for an acute patient, but rather is used for patients with chronic failure as a supportive measure. BiPAP is noninvasive mechanical ventilation that includes CPAP as well as pressure support ventilation. Code 94660 is also reported for the initiation and subsequent management of BiPAP.

ICD-9-CM Diagnostic Codes
464.4 Croup — (Use additional code to identify infectious organism)
478.6 Edema of larynx
478.70 Unspecified disease of larynx
478.71 Cellulitis and perichondritis of larynx — (Use additional code to identify infectious organism)
478.74 Stenosis of larynx
478.75 Laryngeal spasm
478.79 Other diseases of larynx — (Use additional code to identify infectious organism)
490 Bronchitis, not specified as acute or chronic — (Use additional code to identify infectious organism)
508.0 Acute pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.1 Chronic and other pulmonary manifestations due to radiation — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.8 Respiratory conditions due to other specified external agents — (Use additional code to identify infectious organism. Use additional E code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
508.9 Respiratory conditions due to unspecified external agent — (Use additional code to identify infectious organism. Use additional code to identify cause. Use additional code to identify associated respiratory conditions: 518.81.)
510.0 Empyema with fistula — (Use additional code to identify infectious organism: 041.00-041.9)
510.9 Empyema without mention of fistula — (Use additional code to identify infectious organism: 041.00-041.9)
511.0 Pleurisy without mention of effusion or current tuberculosis — (Use additional code to identify infectious organism)
511.1 Pleurisy with effusion, with mention of bacterial cause other than tuberculosis — (Use additional code to identify infectious organism)
511.89 Other specified forms of effusion, except tuberculous
511.9 Unspecified pleural effusion — (Use additional code to identify infectious organism)
513.0 Abscess of lung — (Use additional code to identify infectious organism)
513.1 Abscess of mediastinum — (Use additional code to identify infectious organism)
518.83 Chronic respiratory failure
518.84 Acute and chronic respiratory failure
518.89 Other diseases of lung, not elsewhere classified — (Use additional code to identify infectious organism)
786.03 Apnea
786.04 Cheyne-Stokes respiration
786.05 Shortness of breath
786.06 Tachypnea
786.07 Wheezing
786.52 Painful respiration

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-3,240.4

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99201-99215, 99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350
Also not with 94662: 94660

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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<th>Coding and Payment Guide for Anesthesia Services</th>
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**94760-94762**

**94760** Noninvasive ear or pulse oximetry for oxygen saturation; single determination

**94761** multiple determinations (eg, during exercise)

**94762** by continuous overnight monitoring (separate procedure)

**Explanation**
A sensor is placed on the ear lobe or finger to measure oxygen levels in the blood for a pulse oximetry. A light shines through the capillary bed for the measurement. This code applies to a single measurement.

**Coding Tips**
Code 94762 is designated a separate procedure. It may only be billed separately when performed alone or at the time of an unrelated service or procedure. Separate procedures should not be billed when performed at the time of a related service. Pulse oximetry is included in critical care services and should not be billed separately. Code 94760 is considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100-01999).

**Terms To Know**
**separate procedures.** Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-4, 32, 130; 100-4, 32, 130.1

**CCI Version 20.0**
99241-99245, 99281-99285, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350
Also not with 94760: 94762, 99201-99212, 99215
Also not with 94761: 94760, 94762, 99201-99215
Also not with 94762: 82805

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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**96360-96361**

**96360** Intravenous infusion, hydration; initial, 31 minutes to 1 hour

**96361** each additional hour (List separately in addition to code for primary procedure)

**Explanation**
A physician or an assistant under direct physician supervision infuses a hydration solution (prepackaged fluid and electrolytes) for 31 minutes to one hour through an intravenous catheter inserted by needle into a patient’s vein or by infusion through an existing indwelling intravascular access catheter or port. Report 96361 for each additional hour beyond the first hour. Intravenous infusion for hydration lasting 30 minutes or less is not reported.

**Coding Tips**
If intravenous hydration infusion is less than 30 minutes, then code 96360 should not be reported. Report the appropriate evaluation and management service. As an add-on code, 96361 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Report 96361 in conjunction with 96360. These procedures are considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100-01999).

**Terms To Know**
catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.
intravenous. Within a vein or veins.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**
100-4,4,230.2

**CCI Version 20.0**
E0781
Also not with 96360: 36000, 36410, 36425, 64450, 96372, 96374, 96523, 99201-99215, 99455-99456
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96365

each additional hour (List separately in addition to code for primary procedure)
96366

additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
96367

concurrent infusion (List separately in addition to code for primary procedure)
96368

Explanation
A physician or an assistant under direct physician supervision injects or infuses a therapeutic, prophylactic (preventive), or diagnostic medication other than chemotherapy or other highly complex drugs or biologic agents via intravenous route. Infusions are administered through an intravenous catheter inserted by needle into a patient’s vein or by injection or infusion through an existing indwelling intravascular access catheter or port.

Coding Tips
Report 96365 for the initial hour and 96366 for each additional hour. Report 96367 for each additional sequential infusion of a different substance or drug, up to one hour, and 96368 for each concurrent infusion of substances other than chemotherapy or other highly complex drugs or biologic agents. As add-on codes, 96366–96368 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Report 96366 in conjunction with 96365 and 96367. Report 96367 in conjunction with 96365 and 96374, 96409, and 96413. Report 96368 in conjunction with 96365, 96366, 96413, 96415, and 96416. These procedures are considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100-01999).

Terms To Know
catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.
injection. Forcing a liquid substance into a body part such as a joint or muscle.
intravenous. Within a vein or veins.
prophylactic. Agent or treatment measure intended to prevent or ward off a disease condition.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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IOM References

CCI Version 20.0
Also not with 96365: 36000, 36410, 36425, 64450, 96360, 96372, 96374, 96523, 99201-99215, 99455-99456, E0781
Also not with 96366: E0781
Also not with 96367: E0781
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
98966-98968

**98966**  Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**98967**  11-20 minutes of medical discussion

**98968**  21-30 minutes of medical discussion

**Explanation**
A qualified health care professional (nonphysician) provides telephone assessment and management services to a patient in a non-face-to-face encounter. These episodes of care may be initiated by an established patient or by the patient’s guardian. These codes are not reported if the telephone service results in a decision to see the patient within 24 hours or at the next available urgent visit appointment; instead, the phone encounter is regarded as part of the pre-service work of the subsequent face-to-face encounter. These codes are also not reported if the telephone call is in reference to a service performed and reported by the qualified health care professional that occurred within the past seven days or within the postoperative period of a previously completed procedure. This applies both to unsolicited patient follow-up or that requested by the health care professional. Report 98966 for telephone services requiring five to 10 minutes of medical discussion, 98967 for telephone services requiring 11 to 20 minutes of medical discussion, and 98968 for telephone services requiring 21 to 30 minutes of medical discussion. Do not report 98966–98968 if these codes have been reported within the previous seven days.

**Coding Tips**
Correct code assignment is dependent upon the time of the medical discussion. Report 98966 for telephone services requiring five to 10 minutes of medical discussion, 98967 for telephone services requiring 11 to 20 minutes of medical discussion, and 98968 for telephone services requiring 21 to 30 minutes of medical discussion. Medical record documentation should include the nature and total time of the discussion. Do not report these codes with complex chronic care coordination (99487–99489) or transitional care management services (99495–99496). Coverage of this service varies. Check with third-party payers for their coverage guidelines. When performed by a physician, see 99441–99443.

**Terms To Know**
Assessment. Process of collecting and studying information and data, such as test values, signs, and symptoms.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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98969

Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network

Explanation
On-line medical assessment and management services are provided to an established patient or guardian in response to a patient’s on-line inquiry utilizing Internet resources in a non-face-to-face encounter. Services must be provided by a qualified health care professional (nonphysician). In order for these services to be reportable, the health care professional must provide a personal, timely response to the inquiry and the encounter must be permanently stored via electronic means or hard copy. A reportable service includes all communication related to the on-line encounter, such as phone calls, provision of prescriptions, and orders for laboratory services. This code is not reported if the on-line evaluation is in reference to a service performed and reported by the same health care professional within the past seven days or within the postoperative period of a previously completed procedure. Rather, the on-line service is considered to be part of the previous service or procedure. This applies both to unsolicited patient follow-up or that requested by the health care professional. Report 98969 only once for the same episode of care during a seven-day period.

Coding Tips
This code is used to report nonphysician services only. This code is reported once per a seven-day period regardless of the number of communications (e.g., related telephone calls, additional on-line communications). Medical record documentation should include a permanent storage (electronic or hard paper copy) of the nature and total time of the discussion. Coverage of this service varies. Check with third-party payers for their coverage guidelines. When performed by a physician, see 99444.

Terms To Know
assessment. Process of collecting and studying information and data, such as test values, signs, and symptoms.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4

CCI Version 20.0
No CCI Edits apply to this code.

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99024

Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure.

Explanation
The physician reports this code to indicate a postoperative follow-up visit, normally included in the surgical package when the physician performs an evaluation and management service for reason(s) that are related to the original procedure.

Coding Tips
Follow-up visits performed during the normal, uncomplicated follow-up care of a surgical procedure are not separately reported since they are part of the global surgery package. Some providers use 99024 as a way of documenting follow-up visits that are part of the global service. All of the codes in the range of 99000-99090 describe special physician circumstances and cannot be reported separately. Rather, these codes must be reported in addition to the basic services rendered. Check with the payer for specific guidelines regarding the use of code 99024 and the other codes in this range.

Terms To Know
evaluation and management. Assessment, counseling, and other services provided to a patient reported through CPT codes.
global surgery package. Normal surgical procedure with no complications that includes all of the elements needed to perform the procedure and includes routine follow-up care. Synonym(s): follow-up days, FUD.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
No CCI Edits apply to this code.
99026-99027

99026 Hospital mandated on call service; in-hospital, each hour
99027 out-of-hospital, each hour

Explanation
The code reports the time for hospital-mandated on-call service provided by the physician. This code does not include prolonged physician attendance time for standby services or the time spent performing other reportable procedures or services. Report 99026 for each hour of hospital mandated on call service spent in the hospital and 99027 for each hour of hospital mandated on call service spent outside the hospital.

Coding Tips
Any time spent performing procedures that are reportable separately should not be included in the time reported for mandated on-call services. Physician stand-by services should be reported using code 99360.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
No CCI Edits apply to this code.
Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.

Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service.

Explanation
This code is adjunct to basic services rendered. The physician reports this code to indicate services provided between 10 p.m. and 8 a.m. at a 24-hour facility in addition to basic services.

Coding Tips
These codes are reported in addition to the other services provided during the encounter. Medicare and other third-party payers may not provide additional reimbursement for these codes.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

CCI Version 20.0
No CCI Edits apply to this code.
99056-99060

99056 Service(s) typically provided in the office, provided out of the office
at request of patient, in addition to basic service

99058 Service(s) provided on an emergency basis in the office, which
disrupts other scheduled office services, in addition to basic service

99060 Service(s) provided on an emergency basis, out of the office, which
disrupts other scheduled office services, in addition to basic service

Explanation
This code is adjunct to basic services rendered. The physician reports
this code to indicate services provided on an emergency basis in a
location other than the physician’s office that disrupt other scheduled
office services.

Coding Tips
Report this code in addition to the other services provided during the
encounter. Medicare and other third-party payers may not provide
additional reimbursement when these codes are reported.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present

CCI Version 20.0
No CCI Edits apply to this code.
**99070-99071**

**99070** Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)

**99071** Educational supplies, such as books, tapes, and pamphlets, for the patient’s education at cost to physician or other qualified health care professional

**Explanation**

This code is adjunct to basic services rendered. The physician or other qualified provider reports this code to indicate supplies and materials provided over and above those usually included with an office visit or services rendered. This code does not include eyeglasses; report the appropriate supply code if eyeglasses are provided. List drugs, trays, supplies, and other materials provided when using this code.

**Coding Tips**

Check with private payers to determine if they will accept HCPCS Level II codes instead of code 99070. HCPCS Level II codes often provide a better clinical picture and more appropriate reimbursement than code 99070 or 99071, and should be billed with Medicare claims and many private payers.

**ICD-9-CM Diagnostic Codes**

The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**IOM References**

100-2,15,60.3

**CCI Version 20.0**

No CCI Edits apply to this code.
99080

**99080** Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form

**Explanation**
This code is adjunct to basic services rendered. The physician reports this code to indicate reports such as insurance forms, more than the information in standard communications methods or forms.

**Coding Tips**
Code 99080 should not be reported with code 99455 or 99456 when workers’ compensation forms are completed.

**ICD-9-CM Diagnostic Codes**
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

**CCI Version 20.0**
No CCI Edits apply to this code.

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99100-99140

99100  Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)

99116  Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)

99135  Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)

99140  Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

Explanation
These codes are adjunct to basic services rendered. Code 99100 is reported for anesthesia services performed on a patient younger than 1 year or older than 70 years. See also codes 00326, 00561, 00384, and 00836. Code 99116 indicates that the anesthesia was complicated by the use of total body hypothermia. Report 99135 when anesthesia is complicated by controlled hypotension and 99040 to indicate qualifying circumstances regarding anesthesia complicated by emergency conditions. Specify emergency conditions encountered when submitting a claim.

Coding Tips
As add-on codes, 99100-99140 are subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Report this code in conjunction with the code for the primary anesthesia procedure. Medical record documentation must specifically indicate the need for the hypothermia, hypotension, or the emergent conditions.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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99143-99145

99143 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time

99144 age 5 years or older, first 30 minutes intra-service time

99145 each additional 15 minutes intra-service time (List separately in addition to code for primary service)

Explanation
A physician or other trained health care provider administers medication that allows a decreased level of consciousness but does not put the patient completely asleep inducing a state called moderate (conscious) sedation. This allows the patient to breathe without assistance and respond to commands. This is used for less invasive procedures and/or as a second medication for pain. This code reports sedation services provided by the same provider performing the primary procedure with the assistance of an independently trained health care professional to assist in monitoring the patient. Report 99143 for the first 30 minutes of intraservice time for sedation services rendered to a patient younger than 5 years of age. Report 99144 for the first 30 minutes of intraservice time for sedation services rendered to a patient age 5 years of age or older. Report 99145 for each additional 15 minutes of service.

Coding Tips
As an add-on code, 99145 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Report this code in conjunction with 99143 or 99144.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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CCI Version 20.0


Also not with 99145: 99150

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
99148-99150

99148 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time

99149 age 5 years or older, first 30 minutes intra-service time

99150 each additional 15 minutes intra-service time (List separately in addition to code for primary service)

Explanation
A physician or trained health care provider administers medication that allows a decreased level of consciousness but does not put the patient completely asleep, inducing a state called moderate (conscious) sedation. This allows the patient to breathe without assistance and respond to commands. This is used for less invasive procedures and/or as a second medication for pain. These codes report services provided by a qualified provider other than the health care provider performing the diagnostic or therapeutic service that the sedation supports. These codes are only reported for encounters in a facility setting (i.e., hospital, ASC, SNF) rather than an office or nonfacility setting. Report 99148 for the first 30 minutes of inraservice time for sedation services rendered to a patient younger than 5 years of age. Report 99149 for the first 30 minutes of inraservice time for sedation services rendered to a patient age 5 years of age or older. Report 99150 for each additional 15 minutes of service.

Coding Tips
As an add-on code, 99150 is not subject to multiple procedure rules. No reimbursement reduction or modifier S1 is applied. Add-on codes describe additional inraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as stand-alone codes. Report this code in conjunction with 99148 or 99149.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

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Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.
Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

Explanation
Medical team conferences require the face-to-face participation of at least three participants of different disciplines providing direct care to the patient. The conference may also include the presence of the patient, patient’s family or other guardian or caregiver. Medical team conference participants must have provided direct face-to-face evaluation and/or treatment to the patient within 60 days previous to the conference. Documentation must include a record of participation in the conference, the information contributed by the provider and treatment recommendations provided from others. Only one provider from the same specialty may report a code for this service. If, by contractual agreement, a facility or other organization has agreed to provide a medical team conference, these services should not be billed separately. Team conference services provided by a physician with the patient or patient’s family present are billed using the appropriate evaluation and management codes.

Coding Tips
Some payers may not provide coverage if the patient or patient’s family is not present. Check with third-party payers for coverage guidelines. Do not report these services when duration is less than 30 minutes. When provided by a physician, code 99367 is reported. Do not report medical team conference codes in the same month as complex chronic care coordination services (99487–99489) or transitional care management services (99495–99496). Medicare will not provide benefits for team conferences or telephone calls as these services are considered to be a part of the associated billable service and cannot be reported separately.

ICD-9-CM Diagnostic Codes
The application of this code is too broad to adequately present ICD-9-CM diagnostic code links here. Refer to your ICD-9-CM book.

IOM References
100-2,15,230.4; 100-4,11,40.1.3; 100-4,12,30.6.16

CCI Version 20.0
99358-99359, G0444
Also not with 99366: 99446-99449
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.