

INGENIX®

Anesthesia Cross Coder

*Essential links from CPT® codes to
ICD-9-CM and HCPCS codes*

2009

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CPT Procedure to Anesthesia Code

Anesthesia Cross Coder

72156 01922	73225 01922	74410 01922	01922	01922	01922
72157 01922	73540 01922	74415 01922	76885 01922	77403 01922	78223 01922
72158 01922	73560 01922	74420 01922	76886 01922	77404 01922	78278 01922
72159 01922	73580 01922	74710 01922	76936 01924	77406 01922	78291 01922
72191 01922	73592 01922	74775 01922	76950 01922	77407 01922	78600 01922
72192 01922	73700 01922	75557 01922	76965 01922	77408 01922	78601 01922
72193 01922	73701 01922	75558 01922	76970 01922	77409 01922	78605 01922
72194 01922	73702 01922	75559 01922	77013 01922	77411 01922	78606 01922
72195 01922	73706 01922	75560 01922	77014 01922	77412 01922	78607 01922
72196 01922	73718 01922	75561 01922	77022 01922	77413 01922	78608 01922
72197 01922	73719 01922	75562 01922	77058 01922	77414 01922	78609 01922
72198 01922	73720 01922	75563 01922	77059 01922	77416 01922	78610 01922
72240 01935	73721 01922	75564 01922	77072 01922	77417 01922	78811 01922
72255 01935	73722 01922	75565 01916	77073 01922	77418 01922	78812 01922
72265 01935	73723 01922	75671 01916	77074 01922	77421 01922	78813 01922
72270 01935	73725 01922	75746 01916	77075 01922	77422 01922	78814 01922
72275 01935	74150 01922	75840 01916	77076 01922	77423 01922	78815 01922
72285 01935	74160 01922	75872 01916	77077 01922	77435 01922	78816 01922
72295 01935	74170 01922	75898 01916	77078 01922	77600 01922	79200 01922
73200 01922	74175 01922	75900 01916	77079 01922	77605 01922	79300 01922
73201 01922	74181 01922	76010 01922	77080 01922	77610 01922	79440 01922
73202 01922	74182 01922	76100 01922	77081 01922	77615 01922	90870 00104
73206 01922	74183 01922	76101 01922	77082 01922	77620 01922	91022 00740
73218 01922	74185 01922	76102 01922	77083 01922	77761 01922	91122 00902
73219 01922	74210 01922	76380 01922	77084 01922	77762 01922	91123 00902
73220 01922	74220 01922	76390 01922	77371 01922	77763 01922	92018 00148
73221 01922	74260 01922	76506 01922	77372 01922	77776 01922	92019 00148
73222 01922	74283 01922	76872 01922	77373 01922	77777 01922	92070 00148
73223 01922	74400 01922	76873 01922	77401 01922	77778 01922	92135 00140
			77402	78195	92225

- 581.81 Nephrotic syndrome with other specified pathological lesion in kidney in diseases classified elsewhere — (Code first underlying disease: 084.9, 249.4, 250.4, 277.30-277.39, 446.0, 710.0) ☒
- 582.0 Chronic glomerulonephritis with lesion of proliferative glomerulonephritis
- 583.81 Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, in diseases classified elsewhere — (Code first underlying disease: 016.0, 098.19, 249.4, 250.4, 277.30-277.39, 446.21, 710.0) ☒
- 584.5 Acute renal failure with lesion of tubular necrosis
- 585.1 Chronic kidney disease, Stage I — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.2 Chronic kidney disease, Stage II (mild) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.3 Chronic kidney disease, Stage III (moderate) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.4 Chronic kidney disease, Stage IV (severe) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.5 Chronic kidney disease, Stage V — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.6 End stage renal disease — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.9 Chronic kidney disease, unspecified — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93) ♀
- 586 Unspecified renal failure ♀
- 590.00 Chronic pyelonephritis without lesion of renal medullary necrosis — (Use additional code to identify organism, such as E. coli, 041.4. Code if applicable, any causal condition first)
- 590.01 Chronic pyelonephritis with lesion of renal medullary necrosis — (Use additional code to identify organism, such as E. coli, 041.4. Code if applicable, any causal condition first)
- 590.80 Unspecified pyelonephritis — (Use additional code to identify organism, such as E. coli, 041.4) ♀
- 593.70 Vesicoureteral reflux, unspecified or without reflux nephropathy
- 593.71 Vesicoureteral reflux with reflux nephropathy, unilateral
- 593.72 Vesicoureteral reflux with reflux nephropathy, bilateral
- 593.73 Vesicoureteral reflux with reflux nephropathy, NOS ♀
- 593.81 Vascular disorders of kidney
- 753.12 Congenital polycystic kidney, unspecified type ♀
- 753.17 Congenital medullary sponge kidney
- 866.13 Complete disruption of kidney parenchyma, with open wound into cavity
- 902.42 Renal vein injury
- 902.49 Renal blood vessel injury, other
- 996.81 Complications of transplanted kidney — (Use additional code to identify nature of complication: 078.5, 199.2, 238.77, 279.50-279.53)
- V10.52 Personal history of malignant neoplasm of kidney — (Code first any continuing functional activity: 259.2)
- V10.53 Personal history of malignant neoplasm, renal pelvis — (Code first any continuing functional activity: 259.2)

ICD-9-CM Procedural

- 17.41 Open robotic assisted procedure
- 17.49 Other and unspecified robotic assisted procedure
- 55.51 Nephroureterectomy
- 55.54 Bilateral nephrectomy
- 55.61 Renal autotransplantation

- 55.69 Other kidney transplantation

00870

- 00870** Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; cystolithotomy

Associated CPT Codes

- 51050 Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection

ICD-9-CM Diagnostic

- 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 ♀

ICD-9-CM Procedural

- 17.41 Open robotic assisted procedure
- 17.49 Other and unspecified robotic assisted procedure
- 57.19 Other cystotomy

00872

- 00872** Anesthesia for lithotripsy, extracorporeal shock wave; with water bath

Associated CPT Codes

- 50590 Lithotripsy, extracorporeal shock wave

ICD-9-CM Diagnostic

- 588.81 Secondary hyperparathyroidism (of renal origin)
- 592.0 Calculus of kidney
- 592.1 Calculus of ureter
- 592.9 Unspecified urinary calculus ♀
- 599.70 Hematuria, unspecified ♀
- 599.71 Gross hematuria
- 599.72 Microscopic hematuria
- 788.0 Renal colic

ICD-9-CM Procedural

- 98.51 Extracorporeal shockwave lithotripsy (ESWL) of the kidney, ureter and/or bladder

00880

- 00880** Anesthesia for procedures on major lower abdominal vessels; not otherwise specified

Associated CPT Codes

- 34401 Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision
- 34451 Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision
- 35102 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)
- 35103 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)
- 35131 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)
- 35132 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)
- 35182 Repair, congenital arteriovenous fistula; thorax and abdomen
- 35189 Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen
- 35351 Thromboendarterectomy, including patch graft, if performed; iliac
- 35355 Thromboendarterectomy, including patch graft, if performed; iliofemoral
- 35454 Transluminal balloon angioplasty, open; iliac
- 35482 Transluminal peripheral atherectomy, open; iliac
- 35491 Transluminal peripheral atherectomy, percutaneous; aortic
- 35492 Transluminal peripheral atherectomy, percutaneous; iliac
- 35537 Bypass graft, with vein; aortoiliac
- 35538 Bypass graft, with vein; aortobi-iliac

Appendix: Modifiers for Use with Anesthesia Services

Physical Status Modifiers

All anesthesia services are reported by the use of the anesthesia five digit procedure code (00100–01999) plus the addition of a physical status modifier. Physical status modifiers are represented by the initial letter 'P' followed by a single digit from 1 to 6 defined below.

- P1** A normal healthy patient
- P2** A patient with mild systemic disease
- P3** A patient with severe systemic disease
- P4** A patient with severe systemic disease that is a constant threat to life
- P5** A moribund patient who is not expected to survive without the operation
- P6** A declared brain-dead patient whose organs are being removed for donor purposes

The above six levels are consistent with the American Society of Anesthesiologists (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish among various levels of complexity of the anesthesia service provided.

CPT Modifiers

This is not an all-inclusive list of CPT modifiers, but a list of those commonly used in relation to anesthesia services. For an all-inclusive list of CPT modifiers, see your 2008 CPT book.

- 22 Increased Procedural Services.** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.
- 23 Unusual Anesthesia.** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.
- 32 Mandated Services.** Services related to *mandated* consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.
- 47 Anesthesia by Surgeon.** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

- 51 Multiple Procedures.** When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated add-on codes (see Appendix D of the CPT book).
- 53 Discontinued Procedure.** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
- 59 Distinct Procedural Service.** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
- 99 Multiple Modifiers.** Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and the other applicable modifiers may be listed as part of the description of the service.