Anesthesia & Pain Coder's Pink Sheet

Essential news and guidance to solve your toughest specialty coding challenges

Getting paid: Six documentation tips to get post-op pain blocks paid

Published Dec 2, 2009

Contrary to some payer policies, it is possible to get paid for injection procedures provided for post-operative pain (POP) when you can prove the injections were to control the pain after surgery - and not used to supplement the surgical anesthesia.

Still, getting paid for post-op pain services remains a headache for anesthesia billers.

Get paid the first time

Your documentation must clearly show the post-op pain blocks meet all the requirements to be considered a separately payable service. Here are six tips to ensure your post-op pain blocks are paid:

- Make sure your physician documents that the service was specifically requested by the surgeon (whether that request is verbal or written).
- Document the time spent for the block separately from the anesthesia time.
- Attach modifier **59** to the injection code if it meets the separate billing requirements, reminds Mari Dannenberg, CPC, Anesthesia Resources, Marietta, Ga.
- Make sure the method for administering the block is separate from the method for administering the surgical anesthesia, Dannenberg notes.
- Use diagnosis code **338.18** (other acute post-operative pain) to specify the reason for the block. The secondary diagnosis code should be the specific site of pain where surgery took place. **Example:** If a femoral nerve catheter is placed for total knee replacement, bill **719.46** (pain in joint; lower leg) as the second diagnosis code, Dannenberg recommends.
- Document the type of block/catheter performed in the notes section of the anesthesia record, Dannenberg advises. Describe the post-op pain procedure citing the size of needle used, the type of drug used and whether the test dose was successful, she says.

Winning on appeal

Don't let a carrier denial deter you from payment for these procedures. CPT guidance, CCI edits and even carrier guidance all say you should be getting paid for post-op pain blocks when you document them correctly.

The American Society of Anesthesiologists (ASA) has speculated denials "may be due to payer confusion regarding the difference between regional anesthesia that is applied as part of the primary anesthetic as opposed to that which, while placed prior to the onset of anesthesia, is intended primarily to provide postoperative analgesia." Make sure your payer is aware the procedure was done to treat post-operative pain.

Even when your carrier does not have written guidelines regarding post-op pain blocks, there is plenty of information available from other carriers to assist you in an appeal. The chart on page 8 has a list of payer policies supporting the use of post-op pain blocks you can use to make a case for reimbursement.

Weigh your risks vs. returns

Be sure to weigh the amount of time it takes you to get these procedures paid versus the expected return.

You should determine the number of post-op pain services your practice bills and whether any qualify as separately billable procedures. Remember, the procedure can't be billed as a post-op pain block when the injection is also considered the primary mode of anesthesia - even when the physician states it is for post-op pain.

"I think it depends on the intent for the primary mode of anesthesia," notes Mark DiDonato, assistant administrator/finance director, Anesthesia Services, PA, New Castle, Del.

Example: A patient is having shoulder surgery - a brachial plexus/interscalene block is done and the patient is also sedated (MAC). "I would not bill for the block as post-op pain because the procedure would not normally be done with MAC alone," DiDonato states. "If the block is really the primary mode of anesthesia, it can't be considered as a separately billable procedure, even if the doctor is stating that it is done for post-op pain."

Be cautious when you bill the block separately. You must be sure you can justify payment. Expect both payers and Medicare's Recovery Audit Contractors (RACs) to scrutinize your bills closely.

Official resource:

To view the ASA article on billing nerve blocks, "Reporting Postoperative Pain Procedures in Conjunction with Anesthesia," visit: www.asahq.org/publicationsAndServices/standards/43.pdf

Payer policies on reimbursements for post-operative pain care

Payer	**Policy**	**Documentation**
First Coast LCD - L29258	Medicare will consider peripheral nerve blocks medically reasonable and necessary for conditions such as the following diagnostic and therapeutic purposes ... 7. Nerve blocks as preemptive analgesia A. When a single injection peripheral nerve block provides post-surgical pain control: 1) during the transition to oral analgesics. 2) in those procedures which cause severe pain normally uncontrolled by oral analgesics. 3) in cases otherwise requiring control with intravenous or parenteral narcotics. 4) in cases where the patient cannot tolerate treatment with narcotics due to allergy or side effects, etc.	When preemptive analgesia is performed by a provider other than the surgeon or the anesthesia professional who provides anesthesia/analgesia for the procedure, there must be a compelling patient care reason for the involvement of the additional provider. The rationale for this approach must be clearly documented in the medical record.
Noridian LCD - L24278 Palmetto GBA LCD - L28240	Nerve blocks can be performed for a number of reasons, including: Preemptive - to prevent pain following procedures. Note: Surgeon-administered nerve blocks provided as anesthesia services are considered part of the global surgical procedure and are not reimbursed separately.	Documentation must adequately describe the patient's clinical state (history, physical findings, laboratory and other tests), e.g., identification of the problem including diagnosis, precipitating events, quantity and quality of pain, test results, response to

		previous therapy, the procedure performed including the area injected, the substance(s) injected and the dosage of the substance(s).
National Gov't. Services LCD - L28529	... the advantage to pre-operative placement is that the patient is able to cooperate with the procedure, is not sedated from the operation and therefore is able to report any accompanying paresthesias, the catheter can be properly tested prior to surgery, and the patient will be able to receive pain medications via the epidural space prior to emergence from general anesthesia and may receive benefit from preemptive analgesia.	Reimbursement will be allowed for the initial insertion of the catheter by an anesthesiologist or CRNA on the date of surgery if performed for postoperative pain relief rather than as a measure for providing the regional block for surgical procedures.
Source: Local carrier decisions and carrier policy referenced above		

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