

Billing Strategies for Regional Anesthesia (US)

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Few people can argue that these regional anesthesia techniques add significant non-monetary value to a surgical practice in terms of pain relief, reduced incidence of anesthetic- and opioid-related side effects, and faster recovery.¹⁻⁴ However, gaining this expertise requires an investment of time and money, and the reality at the end of the day is that associating economic value to these procedures will increase their utilization. Although there are no clear guidelines to developing an efficient regional anesthesia practice that employs effective billing strategies, most of my “rules to bill by” are not institution-specific and apply to a wide range of practice environments. Of course, actual payments will vary among practices due to differences in payor mix.

Communication is key

Before you start implementing changes, meet with your practice or department manager to agree on goals. If you utilize a billing service, developing a good relationship with the people involved in sending out your charges is essential. Since they are not directly involved in the provision of healthcare, it is vital to a practice to meet them in person and clearly explain what you do and why you do it. In some cases, when feasible, it is probably worthwhile to have your billing manager observe nerve block procedures and patients’ postsurgical recovery (while preserving patient confidentiality of course). By arming your billing staff with knowledge of your techniques and research, they will be better-equipped to negotiate charges and fair reimbursement with each payor.

Design a separate regional anesthesia procedure note

When nerve blocks are performed for postoperative pain, they are considered separate from intraoperative anesthetic care. Therefore, it is worthwhile to design a distinct procedure note to document the details of these procedures, physician referral, and indication for the procedure (pain diagnosis).^{5,6} Ideally, a different provider performing the procedure and filling out the paperwork even further separates the nerve block from the intraoperative anesthetic technique, but this is arguably not essential. If the nerve block is used for intraoperative anesthesia, this separate form should not be used to avoid inadvertent double-billing, and the appropriate documentation should be included on the anesthesia record. When designing new forms, involve your managers to ensure compliance with hospital policies and mandates from regulatory agencies.

Use appropriate Current Procedural Terminology (CPT) codes and modifiers

While anesthesia billing services are very familiar with CPT codes, we should not expect them to be able to interpret our handwritten procedure notes and deduce the appropriate code. To prevent confusion, we include the current CPT codes for our procedures on our standardized procedure note. For examples of the forms used in our practice, please visit

our website <http://regional.ucsd.edu>. When billing for nerve block procedures performed for postoperative pain management, we also include the modifier -59 to distinguish the block from the intraoperative anesthetic technique.⁶ This is especially important when the same provider performs the nerve block and the intraoperative anesthesia.

Bill for Acute Pain Management and Ultrasound Guidance

Prior to January 2009, the CPT code for continuous nerve blocks included the period of follow-up (10 days). Since the beginning of the year, the Medicare fee schedule has unbundled the follow-up for continuous nerve block catheters, and now we may be able to start claiming daily evaluation and management (E&M) using 99231-99233 for established in-hospital consults. We currently do not know if other insurance carriers will reimburse for E&M or how this change will affect payments for the procedures themselves.

When utilizing real-time ultrasound guidance for nerve block procedures, we employ the CPT code 76942. This code for ultrasound-guided needle placement comes from the radiology section of the CPT book. In order to charge appropriately for the use of ultrasound, your documentation must include an image taken during the procedure and interpretation of findings (limited since this is not a diagnostic code). In our practice, we prefer to print an image and attach it to our procedure note with a text annotation identifying relative anatomy, needle placement, injection of local anesthetic solution, and avoidance of complications. The modifier -26 limits the ultrasound charge to professional fee only. Without the professional fee modifier, 76942 includes a technical component charge for equipment storage and maintenance. While we choose to include the -26 modifier when we bill for ultrasound-guided nerve blocks, this decision is practice-specific and should be determined by the providers and managers involved depends on the model of practice.

In summary, an effective billing strategy for regional anesthesia services takes a hands-on approach. Meet with your practice manager and billing service early to open lines of communication. Assess your resources and invest at least as much time in designing your regional anesthesia practice model as you will in developing your technical expertise. Although actual payments will vary between institutions and geographic locations, incorporating regional anesthesia techniques in your practice will lead to revenue generation in addition to cost containment for the hospital and higher quality recovery for patients.

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