# REPORTING POSTOPERATIVE PAIN PROCEDURES IN CONJUNCTION WITH ANESTHESIA

**Committee of Origin: Economics**

**(Approved by the ASA House of Delegates on October 17, 2007 and last amended on October 20, 2010)**

## 1. INTRODUCTION

ASA has recently received reports of payers inappropriately bundling the placement of epidurals and peripheral nerve blocks for postoperative pain control into the payments for surgical anesthesia services. This is contrary to CPT guidance, CCI edits, Medicare contractors' instructions and the process used to assign base unit values to anesthesia codes. In all probability, this bundling is due to payer confusion regarding the difference between regional anesthesia that is applied as a 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.

**A provider may bill for a regional anesthetic technique as a service separate from the anesthetic if the regional technique is employed primarily for postoperative analgesia and if the following conditions apply:**

**1.1 The anesthesia for the surgical procedure was not dependent upon the efficacy of the regional anesthetic technique –**

For example, if an interscalene nerve block is placed prior to shoulder surgery to effect prolonged postoperative analgesia, then a general anesthetic would have to be used for the actual shoulder surgery rather than simply I.V. sedation in order to properly report the regional block separately. In this setting, if the patient was provided a block and only sedation was added, then it would be clear that the interscalene block was a part of the primary anesthetic rather than a mode of postoperative analgesia.

**1.2 The time spent on pre- or postoperative placement of the block is separated and not included in reported anesthetic time –**

Post surgical pain blocks are most frequently placed before anesthesia induction or after anesthesia emergence. When the block is placed before anesthesia time starts or after it has ended, the time spent placing the block should not be included in reported anesthesia time; this is true irrespective of what level of sedation and monitoring is provided to the patient during that block placement.

**1.3 Time for a post surgical pain block that occurs after induction and prior to emergence does not need to be deducted from reported anesthesia time –**

Time spent on the placement of the post surgical pain block that occurs prior to induction or after emergence is separate and not included in reported anesthesia time. In such cases, it may be necessary to report discontinuous anesthesia time. Sedation given expressly to facilitate placement of the block should not be included in reported anesthesia time.

One excellent means of portraying that the block was a postoperative analgesic is to dictate or record its conduct in the chart in a location *separate from the anesthetic record*. When documenting, it is important to discuss that the surgeon requested that the anesthesia team participate in the provision of postoperative

analgesia, that the patient was involved in the process of defining the best plan for such analgesia and that the patient received additional information about the risks and procedures of such therapy and consented to the procedure, *separate from the information attendant to informed consent for the anesthetic*.

Should there continue to be bundling by a payer of these services, despite following the above guidelines, the practitioner may find the following references of value when corresponding with the payer's representatives.

## 2. CPT GUIDANCE

Some payers may be misinterpreting a portion of the Anesthesia Guidelines found in the CPT book:

> *"The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure."*

However, the question of regional anesthetic procedures for postoperative pain relief has been addressed multiple times by the AMA in its coding guide, *CPT Assistant.* The message has always been consistent: when a pain relief procedure does not serve to deliver the primary anesthetic for a surgical procedure, it is separately reportable from an anesthesia service.

### 2.1 *CPT Assistant*, Volume 7, Issue 2, February 1997 Anesthesia: Coding for Procedural Services

*"…An anesthesiologist could perform a therapeutic nerve block for pain management before or at the conclusion of the surgical procedure, or insert a catheter into the spinal column to induce continuous postoperative analgesia for therapeutic pain management. In the latter case, if an epidural catheter is inserted into the lumbar region, report code 62279*. This code includes insertion of the catheter and initial injection of the analgesic medication or fluid mixture that may then be connected to and controlled by an external infusion pump. Subsequent daily monitoring of the patient may be reported separately using an appropriate E/M code or anesthesia code 01996 because code 62279* does not include daily monitoring. Payor coverage and reporting requirements for daily monitoring services may vary."*

*Note: CPT Code 62319 replaced 62279 in 2000.

### 2.2 *CPT Assistant*, Volume 8, Issue 7, July 1998 Coding Consultation

*"Question: How would you code a pain management service (64400-64530) in conjunction with an operative anesthesia service? The pain management injection (64400-64530) is not the operative anesthesia, but is administered pre, inter, or post- operatively for the purpose of postoperative pain management?*
*"AMA Comment: It is appropriate to report a code from 64400-64530 in conjunction with an operative anesthesia service if an injection, as described by these codes, was also given. The February 1997 issue of CPT Assistant published an article on anesthesia and the coding of procedural services. Under 'Reporting Additional Procedural Services' it reads: "Additional procedural services provided in conjunction with basic anesthesia administration are separately reportable and coded according to standard CPT coding guidelines applicable to the*

*given code and the respective CPT section (eg, Surgery or Medicine sections) in which they are listed.”’Do not code procedural services with anesthesia coding guidelines.”*

### 2.3 *CPT Assistant,* Volume 11, Issue 10, October 2001 Anesthesia and Postoperative Pain Management

This article discusses the circumstances under which a pain procedure is—and is not—separately reportable from anesthesia care when both services are provided by the same physician.

*“It is appropriate to report pain management procedures, including the insertion of an epidural catheter or the performance of a nerve block, for postoperative analgesia separately from the administration of a general anesthetic.*
*…If, on the other hand, the block procedure is used primarily for the anesthesia itself, the service should be reported using the anesthesia code alone…”*

### 2.4 *CPT Assistant,* Volume 17, Issue 5, May 2007 Coding Communication: Question and Answers

This question and answer addressed how time spent placing nerve blocks for postoperative pain control should be reported.

*“Question: Should the time spent placing nerve blocks for postoperative pain control, spinals, arterial lines, etc, be deducted from main anesthesia start and stop times? Would the time spent placing these items need to be deducted from the anesthesia time for the operation? Is there a difference between the arterial line, etc, being placed prior to the patient ‘going to sleep’ or after in regards to discounting this ‘placement’ time?*
*“Answer: The Anesthesia guidelines in the CPT codebook indicate that placement of monitoring devices such as central venous lines, arterial lines, and Swan-Ganz catheters are separately reportable from an anesthesia service. Placement of these monitoring devices have no time associated with them. If a nerve block or epidural is performed for the purpose of postoperative pain management and not as part of the anesthesia for the surgical procedure, then it too is reported separately. When these procedures are performed before the start of anesthesia time, the time spent on them should not be added to the reported anesthesia time because they are separate and distinct from the anesthesia service. If the procedure is performed after induction of the primary anesthetic, it is not necessary to deduct the time spent on the procedure from reported anesthesia time.”*

AMA has also provided guidance on the topic in its publication titled Principles of CPT Coding:

*“In addition to the physical status modifiers, it may also be appropriate to report other CPT modifiers when codes for procedural services are reported in addition to the basic anesthesia service. Remember, if the anesthesiologist performs other additional procedures, each is separately reportable.*

*EXAMPLE*
*A patient undergoing a thoracotomy receives an epidural injection of a local anesthetic for postoperative pain control in addition to the general anesthetic administered through an endotracheal tube.*

*In this case, the epidural (62318) is not the surgical anesthetic (00540) and it would be reported separately as an independent procedure. When general anesthesia is administered and epidural or nerve block injections are performed to provide postoperative analgesia, they are separate and distinct services and are reported in addition to the anesthesia code. Whether the block procedure (insertion of catheter; injection of narcotic or local anesthetic agent) occurs preoperatively, postoperatively, or during the procedure is immaterial*

*EXAMPLE*
*A patient undergoes a total knee replacement surgery, receiving a regional anesthetic and a post operative pain management agent through the same epidural catheter.*

*When the block procedure is used primarily for the anesthesia itself, the service should be reported using the anesthesia code alone (01402).. In a combined epidural and general anesthetic, the block cannot be reported separately.*

## 3. CCI EDITS

The National Correct Coding Initiative (CCI) is a process in which CPT codes are reviewed and analyzed to determine when particular services may or may not be reported together by the same physician for the same patient during a single encounter. The CCI looks for instances of "unbundling" (reporting the individual components of a service instead of the total service) and for code combinations that would be mutually exclusive of each other. Code pairs that could never be reported together have a modifier status indicator of "0." Code pairs that could be reported together under specific circumstances have a modifier status indicator of "1."

The CCI permits the reporting of a pain procedure along with an anesthesia service when appropriate (i.e., when the pain procedure is not used as regional anesthesia for surgery). The edits that pair anesthesia with codes used to manage postoperative pain (such as epidurals and brachial plexus, sciatic and femoral blocks) have an indicator of "1."

The CCI Policy Manual, Version 15.3, Chapter 2 specifically states

> *A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesiologist reports CPT code 01382 (Anesthesia for diagnostic arthroscopic procedures of knee joint). The epidural catheter is left in place for postoperative pain management. The anesthesiologist should not also report CPT codes 62311 (injection of diagnostic or therapeutic substance) or 01996 (daily management of epidural) on the date of surgery. CPT code 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. On the other hand, if the anesthesiologist performed general anesthesia reported as CPT code 01382 and reasonably believes that postoperative pain is likely to be sufficient to warrant an epidural catheter, CPT code 62319-59 may be reported indicating that this is a separate service from the anesthesia service. In this instance, the service is separately payable whether the catheter is placed before, during, or after the surgery. If the epidural catheter was placed on a different date than the surgery, modifier 59 would not be necessary.*

The CCI edits and the current CCI Policy Manual are available at
http://www.cms.hhs.gov/nationalcorrectcodinited/01_overview.asp

## 4. MEDICARE CONTRACTOR INSTRUCTIONS

Medicare contractors provide coding guidance and instructions to providers in numerous ways. Two common methods are including a specialty-specific billing guide on its Web site and issuing Local Coverage Determinations (LCD). Here are some examples pertinent to this issue:

### 4.1 NHIC Anesthesia Billing Guide –

According to the Anesthesia Billing Guide posted on the Web site of NHIC – a Medicare Part A/B Contractor - available at
http://www.medicarenhic.com/providers/pubs/AnesthesiaBillingGuide.pdf

4.1.1 Pain Management
Pain Management Consultation

*Evaluation and management services for postoperative pain control on the day of surgery are considered part of the usual anesthetic services and are not separately reportable. When medically necessary and requested by the attending physician, hospital visits or consultative services are reportable by the anesthesiologist during the postoperative period. However, normal postoperative pain management, including management of intravenous patient controlled analgesia, is considered part of the surgical global package and should not be separately reported.*

4.1.2 Postoperative Pain Control Procedures

*When provided principally for postoperative pain control, peripheral nerve injections and neuraxial (spinal, epidural) injections can be separately reported on the day of surgery using the appropriate CPT procedure with modifier -59 (Distinct Procedural Service) and 1 unit of service. Examples of such procedures include:*

| | |
|---|---|
| *62310-62319* | *Epidural or subarachnoid injections* |
| *64415-64416* | *Brachial plexus injection, single or continuous* |
| *64445-64448* | *Sciatic or femoral injections, single or continuous* |
| *64449* | *Lumbar plexus injections, continuous* |

*These services should not be reported on the day of surgery if they constitute the surgical anesthetic technique.*

*NOTE: Modifier 59 requires that the medical record substantiate that the procedure or service was a distinct or separate services performed on the same day.*

### 4.2 National Government Services – Local Coverage Determination #28529 –

This Medicare Contractor has approved a Local Coverage Determination (LCD) which includes the following statement:

*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.*

## 5. ANESTHESIA CODE VALUATION

Like all CPT codes, new and revised anesthesia codes are evaluated by the AMA/Specialty Society RVS Update Committee (the RUC) and recommendations for the base unit value for these codes are passed on to CMS. The basis for these recommendations is a survey of physicians who perform the service. Following RUC protocol, these physicians are asked to compare the work/intensity/complexity of the new or revised code to that of another code with an established value. The survey used for anesthesia codes includes a clear instruction, "Do not report time or work related to separately billable services such as postoperative pain management procedures or invasive monitoring procedures." Therefore, valuation for an anesthetic code does not include the work of provision of these additional services and payment for them should not be bundled with that of the anesthetic service.