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# Performance and Documentation of Imaging Guidance

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The use of ultrasound guidance for regional anesthesia and pain medicine continues to increase. Recently, new codes for transversus abdominis plane (TAP) blocks (2015, CPT 64486-64489) and paravertebral blocks (2016, 64461-64463) have included the use of imaging guidance. Unlike other codes that only permit fluoroscopy and CT as imaging guidance, these blocks typically include ultrasound guidance when imaging is utilized.

> 64461 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)
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> 64462 Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)
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> 64463 Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)
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> 64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)
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> 64487 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)
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> 64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
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> 64489 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral by continuous infusions (includes imaging guidance, when performed)

It is incorrect to report ultrasound guidance with these procedures. Many other procedures, however, continue to be performed without imaging guidance and therefore ultrasound guidance may be separately reported with CPT code 76942 - *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* - when performed. However, requirements for reporting this service have varied by payer and new CPT® guidance since 2016 establishes minimum threshold guidelines.

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The 2017 text (page 435 of the 2017 CPT® Professional Edition) clearly states, *"A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. With regard to CPT descriptors for radiography services, "images" refer to those acquired in either an analog (ie, film) or digital (ie, electronic) manner."*

Implicit with these instructions is the need for more than just a stored or saved image which must be accessible upon request. These new instructions also require a report signed by the interpreting individual as an integral portion of the procedure. The format or content of this report is not clearly specified, but at minimum should likely identify the key anatomic targets (nerve, artery, vein) and technical factors such as the needle and/or catheter identification and local anesthesia spread. There may be variability among practices in how this is performed.

One way to accomplish this is to develop an electronically generated procedure report, which provides a written description of the key aspects of the procedure. At a minimum, it should include a copy of the ultrasound image that can be attached to a printed procedure note that identifies the patient with a label, the physician(s) performing the procedure, the procedure performed (including side[s]), and the date/time of the procedure. Within the printed image, the key anatomic targets are labeled, as well as the needle/catheter trajectory and local anesthetic deposited. The procedure note (paper) is then placed into the patient's chart and subsequently scanned into the electronic medical record.

Practice patterns may vary, but to assure compliance, the documentation should include:

1. An accessible saved image displaying the procedure and key anatomic components
2. A written and signed report by the interpreting provider
3. Possible additional reporting requirements from your payers

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