

◀ **POST-OP ANALGESIA** Some carriers let you separately report post-op pain blocks.

How to Report Post-op Pain Blocks

Deciphering different post-op pain directives is key to getting the proper reimbursement.

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When it comes to getting paid for post-op pain blocks, not all payors require the same documentation and proof of medical necessity. Some commercial carriers follow the Medicare edits and guidelines while others don't follow Medicare reimbursement — potentially allowing for more aggressive coding and reporting. Here's a review of different post-op pain directives.

- **American Medical Association.** The AMA says it's appropriate to report pain management procedures for post-op analgesia separately from the administration of a general anesthetic. "Whether the block procedure (insertion of catheter; injection of narcotic or local anesthetic agent) occurs pre-operatively, post-operatively or during the procedure is immaterial," reads AMA CPT OCT 01; 9. The AMA lists 2 exceptions, however. One, if the block procedure is used primarily for the anesthesia itself, report the service using the anesthesia code alone. Two, don't report the block separately in a combined epidural/general anesthetic. Keep in mind that even though the AMA allows for separate reporting under specific circumstances, commercial carriers might have varying reporting and billing policies. Be sure to verify them.

- **Centers for Medicare & Medicaid Services.**

CMS says there's no separate payment for post-op pain management when provided by the physician performing an operative procedure, noting on page 6 of the CMS Chapter 2 NCCI Manual that surgeons who provide post-op pain management are reimbursed under a global payment policy related to the procedure. CMS further states that anesthesia practitioners shall not report post-op pain procedures unless "separate, medically necessary services are required that cannot be rendered by the surgeon." In such cases, CMS says "the surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner."

Surgeons may report CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 "only if provided for purposes unrelated to the [post-op] pain management, the operative procedure or anesthesia for the procedure," according to Medicare Global Surgery Rules.

- **Local coverage determination policies.** LCD policies provide documentation and medical necessity essentials for specific procedures. Your MAC/FI may offer LCD policies that provide more specific coding directives for many procedures, including certain pain injections and blocks. Many states don't have a specific LCD policy for the more com-

Read LCDs in Their Entirety

It's easy to misinterpret local coverage determination policies for peripheral nerve blocks if you make it through the medically necessary conditions but omit the remaining contents of the LCD containing the documentation requirements. Take, for example, the following excerpt from First Coast Service Options' LCD:

"Medicare will consider peripheral nerve blocks medically reasonable and necessary for conditions such as the following diagnostic and therapeutic purposes:

When a single injection peripheral nerve block provides post-surgical pain control

- 1. during the transition to oral analgesics*
- 2. in those procedures that 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."*

If you read only the excerpt above and not the LCD in its entirety, you'll miss the remainder of the LCD that reads:

"Based on Medicare rules, regulations and Correct Coding Initiative (CCI) edits, nerve blocks are not separately payable when done by the surgeon or the anesthesia professional who provides anesthesia/analgesia for the procedure. 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. Medical records must be available and submitted upon request."

So even though you can prove medical necessity per the LCD for the performance of the post-op pain block, you must explain why an additional physician had to do the block other than the surgeon or anesthesiologist in the case. But beware. One LCD policy should in no way be interpreted and used as an overall coding policy.

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mon post-op pain block procedures due to the CMS NCCI Manual directive that is already in place. For those states with LCD policies for pain blocks for post-op pain, review the policy — in its entirety (see "Read LCDs in Their Entirety").

Documenting blocks

While most pain management providers are usually on target when describing injection procedures, the ball gets dropped too often when it comes to documenting post-op pain blocks. Detailed documentation is essential and the post-op pain injection must be separate and distinct from the anesthesia used to perform the surgery. Many commercial carriers that allow separate reporting advise a separate operative report or procedure note for the injection. Likewise, many commercial carriers have medical necessity and provider requirements.

We found these examples of grossly deficient post-op pain block dictation within operative reports that provided no separate operative reports for the block:

- "The patient was given a block followed by endotracheal anesthesia."
- "Anesthesia: General endotracheal anesthesia with block."
- "A scalene block was given for post-op pain control."

ON THE WEB

Review your state's LCD policies at www.cms.hhs.gov/determinationprocess/04_lcds.asp



▲ SEPARATELY PAYABLE? If you take the time to read Local Coverage Determination, you'll know whether you can expect to be reimbursed for a nerve block for preemptive analgesia.

Where's the detailed description of the procedure? The clarification of the provider performing the block? The differentiation between the anesthesia for the surgery and the post-op pain block? Follow these documentation recommendations

- Clarify which provider provided the post-op pain service. Who administered the block — the surgeon, the anesthesiologist performing anesthesia for surgery or someone else? AMA and CMS differ in guidelines; verify with carriers.

- Provide the complete description of the block (what, when, why, where, how and meds used) and ensure it is separate/distinct from anesthesia for the surgery. Indicate the medication (steroid, neurolytic or anesthetic); specify the method (catheter, ablation or injection); list the site (cervical, thoracic or lumbar); specify temporary versus permanent placement of catheters; and indicate the specific condition or diagnosis.

- Ensure there is separate/distinct documentation apart from op note describing the surgery.

- Suggest the surgeon dictate the reason for the transfer of care to another provider (medical necessity) when warranted.

Ultimately, expect that you'll need to verify documentation and provider requirements for carriers that allow separate reporting of post-op pain blocks. **OSM**

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