With technological advances in nerve stimulation and ultrasound-guidance, performing the actual peripheral nerve block procedures is easier than ever. 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.\textsuperscript{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. I have found that sitting down with my department’s business, billing, and revenue managers on at least a quarterly basis is highly educational and provides me with frequent feedback on our rapidly-growing practice. Your practice manager can often provide you with the “big picture” – including the overall direction of your institution. For example, a hospital that performs a high volume of orthopaedic surgery may be genuinely interested in a regional anesthesia and acute pain service to reduce recovery room and hospital stays following surgery.\textsuperscript{5,6} The potential cost savings that result from a reduction in room and board expenditures may provide value that outweighs minimal revenue generation and may even warrant a stipend from administration to support the practice.

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.

**Identify your customers**

The truth is that healthcare is a business; and following that same line of thinking, our most important “customer” is the patient. The primary reason for initiating a regional anesthesia program is to benefit patient care. Hospital administrators are also important customers whose support is necessary for a new regional anesthesia program to succeed. As I mentioned, financial support from administration can offset the significant overhead
required to start a regional anesthesia service in terms of personnel, equipment, and training expenses. We must consider our surgical colleagues are customers as well. Surgeons establish contact with patients during their preoperative visits several weeks to months before surgery. Given this long-term doctor-patient relationship, surgeons that support regional anesthesia can recommend nerve blocks to their patients prior to the day of surgery, leading to higher utilization. Therefore, surgeons’ concerns regarding regional anesthesia (such as failed blocks, complications, and case delays) must be addressed. Finally, your partners in the group anesthesiology practice or department must benefit from implementing a regional anesthesia service. If there will be an initial investment, the benefits that result from this new service should apply broadly to the entire group. The ability to recoup this cost is dependent on the model of regional anesthesia practice implemented, the anticipated volume of procedures, effective billing strategies, and reasonable payment.

Assess your resources and develop a system

There are many different ways to incorporate regional anesthesia techniques into an existing anesthesia practice, and it would be impossible to address each one appropriately in a single article. Before you start developing a new regional anesthesia service, some very important questions should be answered ahead of time.

Who will perform the procedures? Depending on the goals of the practice, hiring and/or training staff in specific procedural skills and advanced technology (e.g. surface ultrasound, perineural catheter placement) to develop a core group of skilled personnel is the most important first step. Residency programs have recently created subspecialty regional anesthesia rotations which have led to improvements in training. For anesthesiologists in practice, appropriate training can be obtained by attending conferences and workshops or learning from partners who have received specialized training.

Where will nerve blocks be performed? Commonly, regional anesthesia procedures are performed in the operating room before or after surgery. While this may be the only feasible option for physician-only anesthesiology practices, time in the operating room may be better spent. By performing regional anesthesia procedures in an induction area or preoperative holding room while the preceding case is still in the operating room, operating room efficiency can be improved. This parallel-processing model may not work for every group practice or institution as it depends on the availability of resources and personnel. For anesthesia groups utilizing a care team (supervising anesthesiologists with nurse anesthetists or residents), a “block room” model is recommended.

What do you need? Regional anesthesia procedures require specialized equipment (e.g. nerve stimulators, needles, catheter kits, ultrasound machine) and medications, and centralizing supplies will contribute to effective time management. Storing equipment and supplies in one location, either a block room or at least a regional anesthesia block cart, maximizes efficiency.

How do you “make it work” on the day of surgery? Effective time management in a regional anesthesia system is crucial, and advance preparation is essential. Ideally, surgeons begin to discuss postoperative analgesia including regional anesthesia with the
patient at the surgical scheduling visit. Alternatively, a preoperative preparation clinic 
visit or a phone call from the anesthesiologist the day before surgery to discuss specific 
nerve block techniques can provide patients with early preoperative education to save 
time and minimize patient anxiety on the day of surgery. Patients scheduled for surgery 
amenable to regional anesthesia techniques should be triaged quickly through the 
admissions process to give the regional anesthesia service adequate time to perform nerve 
blocks.

**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). 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 included the current CPT codes for our 
procedures on our standardized procedure note. Not only do my regional anesthesia 
practitioners in an academic institution do their own coding, we even teach our trainees 
about coding and practice management for regional anesthesia. For examples of the 
forms used in our practice, please visit our website [http://regional.ucsd.edu](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. This is especially important when the same provider performs the nerve 
block and the intraoperative anesthesia. 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 
prefere 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.

References

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