REGIONAL ANESTHESIA & NERVE BLOCKS

Quick Reference Guide for Coders & Auditors

Core Principle: Code the documented nerve, plexus, branch, or fascial plane and the documented technique - not simply the surgical site or a familiar block name. Separately reporting a regional block with an anesthesia service also requires that the block qualify as a distinct postoperative pain-management service under the applicable payer's rules.

1. Regional Anesthesia: Start With the Purpose

- Primary anesthetic / intraoperative analgesia: A peripheral nerve block used as the primary anesthetic technique or as a supplement to the primary anesthetic technique is included in the anesthesia service under Medicare NCCI and is not separately reportable by the anesthesia practitioner on the same date of service.
- Postoperative pain management: A peripheral nerve block may be separately reportable when it is performed for medically necessary postoperative pain management, the operating physician requests anesthesia-practitioner assistance, and the block is not required for the adequacy of the intraoperative anesthetic.
- Timing alone does not determine separate reportability. A block may be performed before, during, or after surgery; its purpose and relationship to the intraoperative anesthetic are what matter.
- Review the documentation to determine whether the regional technique was part of the intraoperative anesthesia service or a distinct postoperative pain-management service.

Chart Talk Audit Consideration: Do not determine separate reportability from the block's timing or from the fact that it produced postoperative analgesia. The key question is whether the block was required for intraoperative anesthesia or was a distinct postoperative pain-management service.

2. Single Injection vs. Continuous Catheter

Technique	Coding Concept	Audit Focus
Single injection	One-time injection directed to the documented nerve, plexus, branch, or fascial plane.	Exact target, laterality, purpose, technique, and whether imaging guidance is separately reportable.
Continuous catheter	Catheter placement for continuous infusion. Select the code that specifically describes the documented anatomical target and continuous technique when one exists.	Catheter location, target, laterality, purpose, infusion intent, postoperative management, documentation, and payer requirements.
Multiple blocks	Each separately reported block must be independently supported by the documented anatomy, purpose, medical necessity, and applicable coding rules.	Distinct targets, laterality, medical necessity, NCCI edits, payer policy, and modifier use.

Medicare Catheter Rule: When a continuous peripheral nerve catheter is placed for intraoperative pain management, the catheter placement is included in the anesthesia service on that date, even if it also provides postoperative pain management. Subsequent management requires separate review under the current code set and applicable payer rules.

3. Common Upper-Extremity Targets

Target	Common CPT® Family	Coder's Anatomy Pearl
Brachial plexus	64415 / 64416	Single injection / continuous catheter. Determine the actual neural target from the documentation rather than coding from the approach name alone. Verify current CPT® guidance.
Specific upper-extremity peripheral nerve	Verify current CPT® code set	Select the code that specifically describes the documented nerve or branch when one exists. Do not confuse an axillary anatomical approach to the brachial plexus with documentation of a specific peripheral nerve.
Other peripheral nerve/branch	64450	May apply when the specifically documented peripheral nerve or branch is not described by a more specific CPT® code. Do not use 64450 merely because the block name is unfamiliar or documentation is vague.

4. Common Lower-Extremity Targets

Target	Common CPT® Family	Coder's Anatomy Pearl
Sciatic nerve	64445 / 64446	Single injection / continuous catheter. A popliteal approach may target the sciatic nerve before division. Determine the neural target from the documentation rather than the word “popliteal” alone.
Femoral nerve	64447 / 64448	Single injection / continuous catheter. Distinguish a true femoral nerve block from a more distal saphenous/adductor canal technique based on documentation and current CPT® guidance.
Other peripheral nerve/branch	64450	May apply when the specifically documented peripheral nerve or branch is not described by a more specific CPT® code. Do not automatically default to 64450.
Genicular nerve branches	64454	A specific CPT® code exists for genicular nerve injection services. Verify the current CPT® descriptor, required branches, imaging requirements, and reporting instructions before code assignment.

Chart Talk Anatomy Pearl: Do not code the location - code the structure. “Popliteal,” “adductor canal,” and similar terms may describe an anatomical region or approach rather than the specific nerve being blocked. Use the complete procedure documentation to determine the actual target.

5. Fascial Plane Blocks

- Fascial plane blocks require careful review of the documented anatomical plane, region, laterality, and technique. A named block does not always identify the CPT® code by itself.
- TAP/abdominal wall block families include distinctions for unilateral versus bilateral services and single-injection versus continuous-infusion techniques. Verify the current CPT® code set.
- Do not assume that QL, rectus sheath, PECS, serratus anterior, or another named fascial plane technique should automatically be assigned to an "other peripheral nerve" code. Determine whether the current CPT® code set provides a more specific code for the documented service.
- When the selected fascial-plane code includes imaging guidance, do not separately report imaging guidance already included in that code.
- Do not code from the surgical region alone. The documentation must support the actual anatomical plane or structure represented by the selected code.

Coder's Anatomy Pearl: The name of a block may describe an approach, a fascial plane, a nerve, or a region. Ask: What structure was actually targeted?

Chart Talk Coding Alert: Fascial plane coding has changed over time. Do not rely on older coding habits or automatically default to 64450. Verify the current-year CPT® code family before assigning a code to a named fascial plane block.

6. Ultrasound & Imaging Guidance

- Do not automatically report CPT® 76942 with a regional anesthesia or nerve-block procedure.
- First determine whether imaging guidance is included in the CPT® code assigned to the block. When imaging guidance is included, it is not separately reportable.
- Several commonly reported peripheral nerve-block and fascial-plane block codes include imaging guidance when performed. Always verify the current CPT® descriptor and instructions before considering separate reporting of an imaging-guidance code.
- When imaging guidance is not included in the primary procedure and separate reporting is permitted, verify that the documentation supports the requirements of the applicable imaging-guidance code and payer policy.
- Never unbundle imaging guidance from a procedure whose code already includes that service.

Chart Talk Coding Alert: "Ultrasound guided" does not automatically mean "add 76942." First identify the correct block code and determine whether imaging guidance is already included.

7. Medicare Postoperative Pain-Management Rules

Medicare NCCI: Postoperative pain management is generally included in the surgical global package. The operating physician may request anesthesia-practitioner assistance when separate, medically necessary postoperative pain-management services are required.

- For peripheral nerve blocks within the applicable CPT® range, a block performed on the date of surgery for postoperative pain management may be separately reportable when Medicare's requirements are satisfied, including the applicable operative-anesthesia requirements and when adequacy of the intraoperative anesthetic is not dependent on the peripheral nerve block.
- A peripheral nerve block used as the primary anesthetic technique or as a supplement to the primary anesthetic technique is not separately reportable on the same date merely because it also provides postoperative analgesia.
- When a peripheral nerve block represents a distinct postoperative pain-management service on the date of surgery, Medicare NCCI permits modifier 59 or XU, as applicable, to indicate that it was

administered for postoperative pain management. A procedure note must be present in the medical record.
- Do not determine separate reportability solely from when the block was performed. The purpose of the block and its relationship to the operative anesthetic are critical.
- Continuous-catheter services require additional review of the catheter-placement code, purpose of placement, date of service, and subsequent management rules.

Continuous Catheter Note: Subsequent management of a continuous regional analgesia catheter should be evaluated separately under the current CPT® code set and applicable payer policy. Do not repeat the catheter-placement code simply because the catheter remains in place.

Chart Talk Audit Consideration: A postoperative pain diagnosis, surgeon request, or statement that a block was performed "for postoperative pain" does not by itself establish separate reportability. Review the operative anesthetic, purpose of the block, whether intraoperative anesthesia depended on the block, procedure documentation, NCCI requirements, and payer policy.

8. Regional Anesthesia Documentation & Audit Checklist

Procedure Documentation

- Specific nerve, plexus, branch, or fascial plane targeted.
- Anatomical approach/site and laterality, when applicable.
- Single-injection versus continuous-catheter technique.
- Purpose of the block - primary anesthetic, supplement to intraoperative anesthesia, or postoperative pain management.
- Indication and medical necessity.
- Relevant procedural details necessary to support the service performed.
- Provider identity, date, and appropriate signature/authentication.

When Applicable

- Operating-physician request/transfer of postoperative pain-management responsibility when required.
- Documentation supporting that the block was a distinct postoperative pain-management service rather than part of the intraoperative anesthetic.
- Needle/catheter placement details necessary to support the reported technique.
- Imaging-guidance documentation required by the selected CPT® code and payer policy.
- Documentation supporting separately reported imaging guidance when the guidance is not included in the primary procedure code.

Medicare Postoperative Pain Documentation: When a peripheral nerve block is separately reported on the date of surgery for postoperative pain management, review the record for documentation supporting the operating physician's request, the distinct postoperative purpose of the service, and the required procedure note. The documentation should support that Medicare's requirements for separate reporting are satisfied.

9. Chart Talk Regional Anesthesia Audit Red Flags

The following findings do not automatically mean that a service was incorrectly coded or billed. They indicate circumstances that may require additional documentation review, coding research, or payer verification.

- Block documented by name without sufficient anatomy to determine the actual nerve, plexus, branch, or fascial plane targeted.
- Code selected from the surgical site or block name rather than the documented anatomical target.

- 64450 used as an automatic default because the block name is unfamiliar or the documentation is vague.
- Regional block separately reported when documentation indicates it was the primary anesthetic or a supplement to the intraoperative anesthetic.
- Postoperative pain block separately reported without documentation supporting the applicable Medicare/payer requirements for separate reporting.
- Operating-physician request or postoperative pain-management documentation absent when required by the applicable payer.
- 76942 or another imaging-guidance code separately reported without first determining whether imaging guidance is included in the primary procedure code.
- Single-injection code reported when documentation supports a continuous-catheter technique - or vice versa.
- Multiple block codes reported without sufficient documentation supporting distinct anatomical targets, medical necessity, and separate reportability.
- Laterality or anatomical target on the claim conflicts with the procedure documentation.
- Documentation describes one nerve, branch, or fascial plane while the reported CPT® code represents a different anatomical target.
- Catheter-placement code repeated merely because an existing catheter remained in place, without verifying the appropriate code and payer rules for the subsequent service.

10. Chart Talk Quick Regional Anesthesia Coding Workflow

Step	Review	Key Question
1. Purpose	Determine why the block was performed.	Primary anesthetic, supplement to intraoperative anesthesia, or distinct postoperative pain management?
2. Anatomy	Identify the documented target.	What nerve, plexus, branch, or fascial plane was actually targeted?
3. Approach	Use location/approach to clarify anatomy.	Does the approach identify the target, or only describe the region?
4. Technique	Identify how the block was performed.	Single injection or continuous catheter?
5. Laterality	Review right, left, or bilateral documentation.	Does the reported service agree with the documented side?
6. Code Selection	Select the most specific current CPT® code supported.	Is there a specific code for the documented target and technique?
7. Imaging	Determine whether imaging guidance is included.	Is imaging bundled into the selected code, or potentially separately reportable?
8. Separate Reportability	Review NCCI edits and payer rules.	Is the block separately reportable from the anesthesia/surgical service?
9. Documentation	Confirm the record supports the service.	Are purpose, anatomy, technique, medical necessity, applicable postoperative-pain requirements, and authentication supported?
10. Final Claim Review	Compare documentation with the proposed claim.	Do the code, modifiers, laterality, imaging, and anesthesia service agree with the record?

Chart Talk Note: This workflow is an educational coding and audit framework. It is not a CMS-mandated sequence. Always apply the current CPT® code set, NCCI edits, Medicare requirements, and applicable payer policy.

Coder's Bottom Line

Coder's Bottom Line: Don't code the block name alone - code the documented anatomy, purpose, and technique. Select the most specific current CPT® code supported by the record, determine whether imaging guidance is included, and then determine whether the block is part of the intraoperative anesthesia service or a separately reportable postoperative pain-management service. Anatomy, purpose, technique, documentation, NCCI edits, and payer policy all matter.

Authoritative References

- CMS Medicare NCCI Policy Manual, Chapter 2 - Anesthesia Services, current 2026 edition, effective January 1, 2026.
- CMS Medicare Claims Processing Manual, Pub. 100-04, Chapter 12 - applicable anesthesia, global surgery, and pain-management payment guidance.
- CMS Medicare Coverage Database - applicable Peripheral Nerve Block LCDs and Billing and Coding Articles, when relevant to the jurisdiction and service.
- Current AMA CPT® code set and official CPT® guidelines/instructions for anesthesia, peripheral nerve blocks, fascial plane blocks, and imaging guidance.
- Applicable Medicare Administrative Contractor (MAC), Medicaid, commercial payer, organizational, contractual, and state requirements.

Source Verification Note: Use the current versions of authoritative resources. Coding, billing, documentation, medical-necessity, bundling, modifier, imaging, and reimbursement requirements may vary by payer and may change over time.

Educational Use Only

This quick reference is intended for coding and auditing education. It does not replace the current CPT® code set, CMS/NCCI guidance, MAC, Medicaid, commercial payer, state, organizational, contractual, legal, or compliance requirements. The inclusion or discussion of a code, modifier, service, methodology, or billing concept does not guarantee coverage or reimbursement.