CHART TALK ~ ANESTHESIA CODING CONVERSATIONS

REGIONAL ANESTHESIA & NERVE BLOCKS TIP SHEET

Don't Code the Block Name — Code the Anatomy

The name in the note may describe a location, approach, or nickname. The code depends on what was actually targeted.

WHY THIS MATTERS

Regional anesthesia terminology can be misleading. A block may be documented by the surgical region, injection location, ultrasound approach, fascial plane, or a familiar clinical nickname rather than by the exact nerve or plexus targeted. Coding directly from the block name can therefore lead to the wrong CPT family. The coder must translate the documentation into anatomy first.

THE CODING TIP

Name → Location → Target → Technique → Code. When reviewing a regional block, identify where the needle was placed, what nerve, plexus, branch, or fascial plane was intended to receive the injectate, whether the service was single-injection or continuous catheter, and only then evaluate the applicable CPT code.

THE 5-QUESTION ANATOMY CHECK

1	**WHAT WAS THE BLOCK CALLED?**	Use the documented name as the starting clue—not the final coding answer.
2	**WHERE WAS THE NEEDLE / CATHETER PLACED?**	Identify the anatomical level, region, compartment, or fascial plane.
3	**WHAT STRUCTURE WAS ACTUALLY TARGETED?**	Nerve? Plexus? Specific branch? Fascial plane? Neuraxial space?
4	**WHAT TECHNIQUE WAS USED?**	Single injection, continuous catheter, neuraxial technique, or another documented approach?
5	**WHICH CPT DESCRIPTOR MATCHES THAT ANATOMY + TECHNIQUE?**	Compare the documented target with the exact current code descriptor and applicable guidance.

BLOCK NAME ≠ TARGET NERVE

DOCUMENTED TERM	CODER TRANSLATION
“Popliteal block”	Popliteal describes a region/approach. Determine which nerve or nerve components were targeted.
“Adductor canal block”	Adductor canal describes the anatomical approach/location. Review the documented neural target(s) and technique.
“TAP block”	A transversus abdominis plane block is a fascial-plane technique; do not force it into a named peripheral-nerve code merely because nerves are affected.
“Shoulder block”	The surgical region does not identify the nerve or plexus. Determine whether the documentation supports an interscalene/brachial plexus or another target.
“Ankle block”	A regional label may encompass multiple distal nerves; identify what was actually injected and how the current CPT descriptors apply.

WHAT TO LOOK FOR IN THE BLOCK NOTE

- Block name and stated purpose.
- Laterality and anatomical site.
- Needle insertion location and approach.
- Named nerve, plexus, branch, or fascial plane.
- Ultrasound-described anatomy and needle-tip location when documented.

- Local-anesthetic deposition site—not merely where the skin was entered.
- Single-injection versus continuous-catheter technique.
- Whether multiple targets were injected and whether they represent separate reportable services.
- Whether the block was used for surgical anesthesia, postoperative analgesia, or another purpose.

COMMON CODING MISTAKE

Mistake: The note says “popliteal block,” so the coder searches for a CPT code using the word popliteal and selects a code from the label alone.

Better approach: Determine what neural structure was targeted at the popliteal level, review the documented technique, and compare those facts with the exact current CPT descriptors.

ANATOMY BEFORE CPT

Injection location ≠ block name ≠ target nerve ≠ CPT code

Those concepts may overlap, but they are not interchangeable. The coder's job is to connect them using the clinical documentation and current coding guidance.

CODER'S TIP

Draw an invisible arrow: Where did the needle go? → What structure was there? → What was the clinician trying to block? → What code describes that target and technique? This is especially helpful when the documented block name is regional rather than anatomical.

QUICK EXAMPLE

Scenario: The anesthesia note documents a “regional block” using a familiar location-based name. The procedural detail identifies the needle approach, ultrasound landmarks, and the specific neural structure around which local anesthetic was deposited.

Coding point: Code from the documented anatomical target and technique after comparing them with the current CPT descriptor. Do not allow the shorthand block name to override the detailed procedure note.

WHEN TO STOP AND REVIEW

- The block name and detailed anatomy appear inconsistent.
- The note gives only a location-based nickname with no identifiable target.
- More than one nerve or branch is documented and separate reporting is being considered.
- The documented technique could represent a fascial-plane block rather than a named nerve/plexus block.
- The block was used as part of the primary anesthetic and separate postoperative-pain reporting is being considered.
- The proposed code depends on assumptions about anatomy that are not supported by the record.

AUTHORITATIVE RESOURCES

- Current AMA CPT code set — verify exact peripheral nerve/plexus and fascial-plane block descriptors and instructions.
- Current CMS Medicare NCCI Policy Manual — review anesthesia and postoperative pain separate-reporting rules when applicable.
- Current payer policy — verify coverage, bundling, modifier, ultrasound-guidance, and documentation requirements.
- Anatomical references — use reputable anatomy resources to understand the documented target, but base coding on the clinical record and official coding guidance.

BOTTOM LINE

Don't ask, “What did they call the block?” Ask, “What did they actually block?”

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