CHART TALK ~ ANESTHESIA CODING CONVERSATIONS

REGIONAL ANESTHESIA & NERVE BLOCKS TIP SHEET

TAP vs QL Blocks: Understanding Fascial Plane Coding

For fascial plane blocks, the documented plane and approach matter more than the nickname.

WHY THIS MATTERS

Transversus abdominis plane (TAP) and quadratus lumborum (QL) blocks are fascial plane techniques used for abdominal and truncal analgesia. QL terminology can be especially confusing because QL1, QL2, QL3, and intramuscular approaches describe different needle-tip locations around or within the quadratus lumborum muscle. The coder should identify the documented fascial plane, laterality, and technique before selecting the applicable code.

THE CODING TIP

Do not code the acronym. Code the documented fascial plane. Determine where the needle tip was positioned and where local anesthetic was deposited. Then compare that anatomy with the current CPT descriptors for TAP/abdominal wall fascial plane blocks, including unilateral versus bilateral and single-injection versus continuous techniques.

TAP AND QL: ANATOMY AT A GLANCE

TECHNIQUE	GENERAL ANATOMICAL CONCEPT	CODER FOCUS
TAP	Injection into the transversus abdominis fascial plane of the abdominal wall	Confirm plane, side(s), and single vs continuous technique.
QL1 / Lateral QL	Injection generally lateral to the quadratus lumborum muscle	Identify the documented needle-tip/deposition plane rather than relying on “QL1.”
QL2 / Posterior QL	Injection generally posterior to the quadratus lumborum muscle	Confirm posterior fascial plane documentation.
QL3 / Transmuscular QL	Needle passes through QL with deposition in a deeper plane between QL and psoas major	Distinguish from lateral/posterior QL based on actual deposition site.
Intramuscular QL	Injection within the quadratus lumborum muscle	Verify exact technique and current coding guidance before assignment.

CURRENT CPT FAMILY: START WITH THE TECHNIQUE

For current coding, abdominal wall fascial plane block descriptors distinguish unilateral versus bilateral services and single-injection versus continuous-infusion techniques. When a QL block is documented, determine whether the documented technique fits the applicable TAP/abdominal wall fascial plane code family under current CPT guidance. Do not default to an “other peripheral nerve” code simply because the block is called QL.

THE FOUR-CODE DECISION

CODE	TECHNIQUE CONCEPT	VERIFY
64486	Unilateral, single injection	One side + supported single-injection fascial plane service.
64487	Unilateral, continuous infusion by catheter	One side + supported catheter/continuous technique.
64488	Bilateral, single injection	Both sides + supported bilateral single-injection service.
64489	Bilateral, continuous infusion by catheter	Both sides + supported bilateral catheter/continuous technique.

WHAT TO LOOK FOR IN THE BLOCK NOTE

- Block name: TAP, QL, QL1, QL2, QL3/transmuscular, intramuscular, or another documented term.
- Exact needle-tip and local-anesthetic deposition location.
- Relationship to the quadratus lumborum, psoas major, transversus abdominis, and surrounding fascial layers.
- Unilateral versus bilateral performance.

- Single injection versus continuous catheter.
- Ultrasound guidance and image/report documentation when relevant.
- Purpose of the block and relationship to the primary anesthetic.
- Whether multiple injections represent one bilateral service, different approaches to the same service, or truly distinct reportable procedures.

COMMON CODING MISTAKES

- Reporting 64450 simply because QL is not the name of a peripheral nerve.
- Choosing a code from “QL1,” “QL2,” or “QL3” without reviewing the documented deposition plane.
- Reporting two unilateral codes instead of evaluating the bilateral descriptor when a bilateral service is performed.
- Treating a long-acting single injection as a continuous block.
- Separately reporting ultrasound guidance without verifying whether current code descriptors or payer rules include/bundle the imaging.
- Reporting a postoperative pain block separately without evaluating NCCI and payer requirements.

CODER'S TIP

For QL blocks, ask: “Where did the local anesthetic land?” That answer is more useful than the QL number. Once you understand the deposition plane, determine side and technique, then verify the current CPT family.

QUICK EXAMPLE

Scenario: The anesthesia record documents bilateral ultrasound-guided QL blocks for postoperative analgesia. The detailed note identifies the fascial plane on both sides and documents a single injection on each side with no indwelling catheter.

Coding point: Evaluate the current bilateral single-injection abdominal wall fascial plane descriptor rather than automatically reporting an “other peripheral nerve” code or two unilateral services. Separate reporting from the primary anesthetic must still satisfy applicable NCCI and payer rules.

WHEN TO STOP AND REVIEW

- The note says only “QL block” with no anatomical approach or deposition site.
- The QL label and detailed ultrasound anatomy conflict.
- Unilateral versus bilateral performance is unclear.
- A catheter is mentioned but continuous infusion is not supported.
- Multiple QL/TAP injections are documented and multiple codes or units are being considered.
- The proposed code is based on an old coding convention rather than the current year's CPT guidance.
- The block is being separately billed with anesthesia and postoperative-pain requirements have not been verified.

AUTHORITATIVE RESOURCES

- Current AMA CPT code set - verify descriptors and instructions for 64486-64489 and applicable fascial plane block guidance.
- Current CMS Medicare NCCI Policy Manual and PTP edits - review bundling and postoperative pain reporting.
- Current payer policy - verify coverage, modifiers, bilateral reporting, units, ultrasound guidance, and documentation requirements.
- Reputable clinical anatomy references - use to interpret TAP and QL fascial planes while basing final coding on official coding guidance.

BOTTOM LINE

QL is the block name. The fascial plane, side, and technique drive the coding decision.

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