The Three "C's" of Documentation in Regional Anesthesia: Consent, Care, and Compliance

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Objectives: After attending this presentation, the participant will have a better understanding of the issues surrounding documentation of regional anesthesia procedures as they relate to (1) documentation of the process of consent (2) documentation of clinical care (3) and documentation of information specifically required to meet compliance with the health car initiatives of regulatory agencies and for billing.

Documenting Regional Anesthesia Specific Consent:

Of the three 'C's" of documentation, written anesthesia consent is most likely the most controversial of the bunch. Some advocate documentation of consent specific to regional anesthesia procedures (the author's strong bias), while others make strong arguments eschewing all written consent for anesthesia due to the creation of redundancy or worse.[1,2]

Informed consent can be thought of as a process with three elements: disclosure of medical information, patient understanding (or competency), and mutual decision-making. Because consent isn't a 'form' but a process of interaction between people, documenting the adequacy of the informed consent is difficult if not impossible for any medical treatment including regional anesthesia. Despite the difficulty, using a ***form*** to document the conduct of the informed consent ***process*** as it relates to regional anesthesia may have advantages in all three of these steps of the consent process---and benefit beyond relying on verbal informed consent alone. First, a well constructed informed consent form may guide the process of informed consent by providing scripted information. For example, most state legislatures in the United States have upheld the idea that the disclosure of risk during the informed consent process should cover those risks that are common and those that are the most serious. A document can be used to guide such disclosure as a matter of routine, so that those things the anesthesia department or group agrees upon are that much more likely to be disclosed properly. Second, written consent has been shown to improve recall of risk and benefits which may improve patient understanding of medical therapy. Third, because regional anesthesia is often viewed as an optional therapy in addition to/or beyond general anesthesia, patient's and physicians medical decision making must incorporate a discussion of both benefit and risk. A written consent form that is able to document both the benefits and risks of regional anesthesia may better document that this process of decision making truly occurred. Such a form could be in itself viewed as a patient education document[3].

Most studies of informed consent have focused on therapies besides regional anesthesia. However, one study has examined informed consent for epidural labor analgesia where it has been found to enhance recall[4]. Almost all studies examining informed consent in medicine have centered on the issue of patient recall. These have universally demonstrated extremely poor rates of recall. With verbal consent, recall has been found to be adversely effected by the style of presentation. With written consent, recall has been found to be dependent on format of the form. Written consent has been found to be recalled best when the patient signs a

consent form which is brief, an opportunity to discuss the written form is available, and the patient is given a copy of the signed consent document.[3] Below is a copy of the consent form our institution uses. At the composition of this manuscript, this form it is on the verge of becoming fully electronic and is to incorporate home going instructions and an electronic patient signature.

This example of an anesthesia risk disclosure form[5] will not be ideal for each practice. The reader is encouraged to adapt this form to his or her practice keeping the following points in mind:

1. The form should be as brief as possible.
2. It should be written to as close to a seventh grade reading level as possible.
3. Risks and benefits should be covered to mirror the true process of consent.
4. The form should not use "boiler-plate" language in long paragraph form.
4., The form should provide the patient with information.

Documentation of Regional Anesthesia Patient Care:

While practices in regional anesthesia have become more expansive, forms and computer applications to easily document these procedures has not yet gained widespread acceptance. Despite the complexity of our practice, many of us document regional procedures in a one inch square of our institution's anesthesia record. Often this record has been designed for the purpose of documenting general not regional anesthesia. Very few published descriptions of documentation or regional anesthesia procedures exist. However, surveys of anesthesia records have noted space for, or narrative details regarding, regional anesthetics in 2-30% of surveyed standard forms documenting anesthetics. Other publications have described the development and assessment of individual anesthesia records. These authors have developed forms for documenting anesthetics with the pooled expertise at individual and multiple institutions.[6]

Below is also an example of a peripheral nerve block form [5] which will also not be ideal for each practice. The reader is encouraged to adapt this form to his or her practice.

Department of Anesthesiology

(Patient name label)

ANESTHESIA REQUEST RISK DISCLOSURE FORM

We select the type of anesthesia based on what we normally plan for your surgery, your medical condition, and what your surgeon prefers. Anesthesia is also planned based on what you want. Please use this form to understand what we do for anesthesia and to show that you give consent.

An Explanation of Anesthesia and Pain Relief

☐ **General Anesthesia (with or without a breathing tube)**	Technique	Medicines put into your IV will make you unconscious. A breathing tube may be put into your windpipe or throat after you are unconscious. Medicine breathed through this tube will keep you unconscious while a machine may breathe for you. If numbing medicines are used to keep you comfortable, you will likely not need a breathing tube, medicines breathed in, or a breathing machine. Instead, constant IV medicines will keep you asleep.
	Expected Result	You will not be aware during surgery.
	Specific Risks	Nausea and vomiting, mouth or throat pain, hoarseness, injury to mouth, teeth or eye, breathing stomach contents into the lungs, Pneumonia, permanent weakness, numbness, or pain from a nerve injury. Becoming aware of what's going on during surgery.
☐ **Epidural, Spinal, or Caudal Anesthesia**	Technique	Medicine put through a needle or tube between the bones of your back will numb your body.
	Expected Result	You will temporarily lose feeling and movement to the lower part of your body, or to your chest and belly. You will have pain relief for a period of time after surgery.
	Specific Risks	Nausea and vomiting, headache, backache, or having a seizure, permanent weakness, numbness, or pain from a nerve injury.
☐ **Peripheral Nerve Block**	Technique	Medicine put through a needle or tube near nerves of your arm, leg, chest, or belly will numb your body.
	Expected Result	You will temporarily lose feeling and movement of all or part of a limb, your chest, or belly. You will have pain relief for a period of time after surgery.
	Specific Risks	Soreness or bruising, injury to a blood vessel, having a seizure, permanent weakness, numbness, or pain from a nerve injury. Lung collapse with specific types of peripheral nerve blocks.
☐ **Bier Block**	Technique	Medicine put through an IV into a vein of your arm.
	Expected Result	You will lose feeling and movement of an arm during surgery.
	Specific Risks	Having a seizure, injury to blood vessels, or permanent weakness, numbness, or pain from a nerve injury.
☐ **Sedation**	Technique	Medicine put into your bloodstream through an IV will make you less aware.
	Expected Result	You will be less aware and less anxious during surgery.
	Specific Risks	Nausea and vomiting, slowed breathing, injury to a blood vessel.

An Explanation of Special Procedures

☐ **Arterial Line** ☐ **Central Line** ☐ **Pulmonary Artery Line** ☐ **TEE** ☐ **Lumbar Drain** ☐ **Intubation while Sedated** ☐ **Postoperative Ventilation**	Technique	☐ a tube put in an artery of your arm or leg to monitor pressures ☐ a tube put in a vein of your neck or chest to monitor pressures ☐ a tube put in your neck or chest to monitor heart pressures ☐ an ultrasound probe put into your throat to monitor your heart ☐ a tube put between the bones of your back to remove spinal fluid ☐ a breathing tube put in with you breathing and sedated for safety ☐ a breathing tube left in after surgery for your safety
	Expected Result	Better safety of anesthesia or surgery care, monitoring, blood sampling, or putting medicines into veins
	Specific Risks	☐ Injury to blood vessels and heart. ☐ Lung collapse. ☐ Irregular heart rhythm. ☐ Mouth or throat pain, hoarseness, injury to mouth or teeth. ☐ Headache, backache, or permanent weakness, numbness, or pain from nerve injury.

Consent for the Transfusion Blood or Blood Components

☐ **I hereby authorize and consent to the transfusion of blood or blood components during my treatment at NCBH.** ☐ **I will not accept a blood transfusion as a life saving measure.**	I hereby acknowledge that I understand the following list of items or that they have been explained to me: • I understand that I may need a transfusion of blood or one of its components in the interest of my health and proper medical care. I understand what a transfusion is and the procedures that will be involved. • Although the blood has been carefully tested, I understand there are possible risks such as unexpected reactions or transmission of viral hepatitis, AIDS, and other infectious agents. • Alternatives to blood transfusion, if any, have been explained to me. • I understand that no guarantee as to the outcome of these transfusions has been made. • I understand that I may revoke this consent for a transfusion at any time.

All types of anesthesia carry some risk of severe complications. Although rare, these include infection, drug reactions, blood clots, paralysis, stroke, heart attack, brain damage, and death. Anesthesia could injure a fetus if you are pregnant. Sometimes, the type of anesthesia may be changed during surgery to better care for you or aid the surgeon's task.

I have read this form or had it read to me. I understand what it says. I have been given a chance to ask questions and have them answered. Types of anesthesia, special procedures, and transfusions have all been explained. I have enough information to give my permission to use these as needed.

_____ _____

Signature of the patient (or the patient's legal representative authorized to sign for the patient)

Witness (only necessary in the event of telephone consent or if the patient signs with an "X" mark)

I have discussed the contents of this form with the patient (or legal representative authorized to sign).

_____ _____ ____/____/____ (____:____)

Person obtaining the signature Physician obtaining consent Date Time

PERIPHERAL NERVE BLOCKADE

Peripheral Nerve Block(s) performed

Approach: _____ ☐ **Left** ☐ **Right** side confirmed

Indication: ☐ Analgesia ☐ Surgical anesthesia Dx/pain location:_____

☐ Specifically requested for management of pain by Dr. _____

Date: ____/____/20____ **Start time** (:) **End time** (:)

Pt Condition: **Intitial BP:**____/____ **HR:** ____ **VAS Pain score:** **0 1 2 3 4 5 6 7 8 9 10**

☐ awake ☐ sedate with meaningful contact maintained

☐ PNB performed under spinal / epidural / general anesthesia. Indication: _____

Preparation: ☐ povidone-iodine ☐ chlorhexidine ☐ iodophor/isopropyl ☐ alcohol ☐ drape

Position: ☐ supine ☐ prone ☐ LLD ☐ RLD ☐ sitting

Needle(s): ☐ short-bevel ☐ Tuohy ☐ long-bevel ☐ pencil-tipped

Manufacturer, length, gauges: _____

Technique: ☐ injection through needle ☐ catheter placement **(depth at skin_____cm).**

☐ nerve stimulation ☐ infiltration ☐ ultrasound

☐ paresthesia. describe quality of paresthesia :_____

Motor response or paresthesia obtained	mA	mS	depth (cm)	Sedation Given	mg/mcg
				Midazolam	
				Fentanyl	

Injectate: ☐ **bupivacaine** ☐ **ropivacaine** ☐ **mepivacaine** ☐ **lidocaine** ☐ **2-CP**

Concentration (%)	Volume (mL)	Adjunct	Epinephrine
			☐ **1/___00,000**
			☐ not used

Narrative: Injection was made incrementally with constant monitoring and aspiration every _____ mi s.

		Action Taken
Blood aspirated:	☐ no ☐ yes	
Intravenous test using epinephrine:	☐ negative ☐ positive	
Pain on injection noted:	☐ no ☐ yes	
Resistance on injection	☐ normal **Events:** ☐ high	☐ difficult:

Resista

Success: ☐ complete ☐ partial ☐ failed ☐ aborted ☐ full evaluation pending

Pt Condition: **Post BP:**____/____ **HR:** ____ **VAS Pain score:** **0 1 2 3 4 5 6 7 8 9 10**

☐ The procedure was performed by _____(sign). I was present and medically directed.

☐ I performed the procedure myself. **ATTENDING MD SIGNATURE:** _____

The authors describing creation of this standardized peripheral nerve block form above list the following key elements in regional anesthesia documentation: name of block(s) performed, approach used, patient condition, indications for blockade under general anesthesia or neuraxial block, aseptic agent used, patient position, needle design (tip, manufacturer, length, gauge), technique, single injection or catheter, catheter type, depth of insertion, technique (method of needle localization), description of parasthesia and its quality, description of motor response(s) obtained, type and quantity or sedation administered, minimal current and current duration, needle depth prior to injection, local anesthetic(s) used, concentration, volume, epinephrine dose used, additives used, note of incremental injection and monitoring, note of aspiration and action taken, note of test dose and action taken, note of monitoring for pain on injection and action taken, note of monitoring for resistance on injection and action taken, narrative of events during the procedure, adequacy of blockade, patient vital signs following procedure, patient visual analog scale pain score following procedure.[6]

Often providers tell me they feel the need to document more or certain aspects of care for 'medico-legal' reasons. My experience as an expert in the legal arena suggests to me that this is not always the best course. While it is good exercise to periodically contemplate how our documenting might appear blown-up on a 3x 5 foot poster board in a court room, it is generally incorrect to document in the medical record anything that is not directly related to medical care. In my experience it is especially unhelpful to have two providers document the same activity twice, to re-document specific data already in the record, document more than an hour after you stop caring for your patient, document in such a way as to make documentation appear coincident with patient care when it cannot be, and of course to ever document something before it happens. There are exceptions to every suggestion, but it is important to think about the legal implications of our words and phrases. Here are a few "Highlights"[7] of my opinions. These are only included because they are actual documentation from real cases now settled. I have contrasted these actual statements (some of which do not really seem that problematic until a specific problem appears) with my own alternative statements submitted only as suggestions:

Dr Goofus	**Dr Gallant**
Heavily sedated	Sedate with meaningful contact maintained
mA<0.5	mA=0.3
Patient refuses regional anesthesia	After detailed discussion of risks, benefits, and alternatives, patient requests GETA at this time.
INR=1.4, okay for spinal	Despite elevation of INR, I believe a careful assessment of risk and benefit favors spinal in this patient. I discussed these risks and benefits with the patient who would like to proceed with spinal anesthesia plus sedation.
Neuro exam normal per patient	Patient denies weakness or numbness.
patient seized after local was inadvertently injected IV	seizure followed two minutes after a 5cc injection intended for the epidural space followed a negative IV test dose of 3cc 0.5% bupivacaine plus 1:300,000 epinephrine. The injection was immediately stopped.
Patient had a severe paresthesia during axillary block	Patient had a transient paresthesia upon needle placement: needle was removed and no local injected at this location.

Documentation of Regional Anesthesia for Compliance:

All documentation for reasons of compliance whether it is for regulatory or billing purposes have one thing in common: the "rules" governing documentation do not always make sense, seem fair, or wind up being particularly easy to remember and implement. In the author's opinion, this aspect of documentation is best dealt with using the same part of ones brain our legal colleagues and tax consultants use. I think this is a different part of one's brain than used for planning an evidence-based anesthetic. Therefore, not every competent anesthesiologist has the patience or disposition to design a good form or computer program to deal

with such issues, but probably someone in your department or group does. My advice is to leave it to him or her and do whatever he or she comes up with. For peripheral nerve blocks, a recent publication[5] listed the following elements important for regulatory and billing compliance: patient identification, site and side of blockade, patient diagnosis, pain location, indication for procedure, request by surgeon for placement of block for analgesia, site and side verification of blockade, baseline vital signs, baseline visual analog scale pain score, date of procedure, procedure start and end times, and a signature line with a statement for presence/ medical direction/ or performance.

The most current and pressing regulatory documentation issue related to regional anesthesia procedures is the need to document the Universal Protocol that is part of the 2009 National Patient Safety Initiative instituted by Joint Commission for the Accreditation of Health Organizations as of January 2009. In addition, the practice of regional anesthesia must be conducted in such a way as not to interfere with these same initiatives as they apply to surgical site marking and time out[8]. Like all compliance initiatives, the language of this relatively new initiative is very specific yet not completely clear or wholly consistent. The language does very specifically direct itself to two specific common activities in the provision of regional anesthesia care.

Documentation of Regulatory Compliance (Transfer of Care):

Whenever one provider transfers anesthesia care to another provider at any point during the anesthetic and surgery, a process must be in place where each provider assures that the correct patient is having surgery on the correct site, and correct side. For example, "I have re-affirmed that Mr. Joseph Bagodonuts is the correct patient having surgery on the correct side and site upon transfer of care from Courtney Sparkles CRNA--Eddie Frecker MD." This process must be both documented and measurable. Documented means in some way the process is recorded. Measurable means that the degree of compliance with this process is known. This is not easy to do. Because of the increasing need for measurement of compliance, computerization of documentation seems inevitable to the author.

Documentation of Regulatory Compliance (Site/Side Marking and Time Out for Regional Anesthesia Procedures):

The same procedures for Universal Protocol and surgical procedures is required for anesthesia procedures. Examples of anesthesia procedures which require Universal Protocol are all regional procedures regardless of sidedness, and central lines, while examples that do not need such attention are arterial lines, peripheral IV's, transesophageal echos, and peripheral IV's.

Documentation of Billing Compliance:

The topic of billing for regional anesthesia procedures is confusing. Billing correctly is not just important for the health of your group or department: doing it wrong by over-billing is called 'fraud'. Fraud can get you in trouble.

Ideally your group or department has a billing service or compliance office that looks out for both. In my personnel experience, an academic institution's compliance offices may seem more conservative in

preparation for review by governmental oversight agencies, while private practice groups and billing services may encourage more liberal billing practices.

Basically, the main issues surrounding billing for regional anesthesia can be distilled down to three basic requirements:

1. Requirement to document that **regional analgesia blockade** is separate from the OR anesthetic.

In order to bill a professional fee for any type of block separate from the anesthetic, the reason for performing the block must be for the provision of postoperative pain relief. Your anesthesia group or department does not automatically get financial credit for both just because your block happens to achieve both. Instead, for each patient the anesthetic needs to be defined as such and the analgesia block needs to be defined as such by the anesthesia provider. For the sake of your billers, your institution or group should probably develop some straightforward guidelines for what constitutes an anesthetic block versus what constitutes a block for postoperative pain. Using the type of local injected (e.g. long or short acting) may help. In defining general anesthesia, considering propofol plus ketamine infusion as a form of general anesthesia may help make this distinction as well.[9,10] If a different provider provides the regional block than the provider who provides the anesthetic, the distinction may be clearer still. In any case your billers will submit a specific CPT prodedural code for each type of regional block used for pain management. **The billing distinction between anesthesia and analgesia is made when these codes are submitted with a -59 modifier to indicate block placement for post-operative analgesia, separate from anesthesia care.**

Alternatively, if the regional anesthetic procedure is in fact performed for anesthesia and not pain management, then the time required to perform the procedure outside the operating room can be added as 'non-continuous care' to the time it took to do the rest of the anesthetic in the OR. (For procedures performed inside the operating room this should not be necessary.) Vital signs must be documented in the medical record around the time period of such block placement when the block is used as the primary anesthetic. In fact, once time is being billed for an anesthetic, the same standards as used for an anesthetic (physiologic monitoring, personnel utilization, and medical direction)—whether the patient is in the operating room or a regional block area should be followed. There are several procedural codes that can be used to indicate that these procedures are being used for postoperative pain management rather than for anesthesia. The most important changes to these codes were last in 2009 when the global period for peripheral nerve block catheters was eliminated so that placement and analgesia management are no longer combined into one code:

CPT Code	Description	Global Surgical Reduction
64416 64446 64448 64449	Continuous Brachial Plexus Block Continuous Sciatic Block Continuous Femoral Nerve Block Continuous Lumbar Plexus Block	Global days reduced from 10 to 0.

In addition, CPT codes for analgesia blocks are submitted in association with category or site codes which are intended to indicate the location of the pain treated and the nature of the analgesia provided:

Code	Type of Code	Description
338.11-338.40	Category specific pain	Acute or chronic pain, trauma, post-thoracotomy, post-op, other
608.9-786.50	Site specific Pain codes	Pain in joints, limbs, genital organs to facial locations

2. Requirement to document that **regional analgesia management** is separate from routine postoperative surgical care.

You can only bill for blocks for postoperative pain management if requested to do so by the surgeon. When blocks are performed for postoperative pain management an attestation that the attending surgeon requested the block must be present. Some institutions require an "order" signed by the surgeon, while others use an attestation by the anesthesia provider to this effect in its place. Remember that (unlike anesthesia providers) the surgeon's professional re-imbursement for the surgery is bundled with patient management. This includes pain management. To unbundle and charge separately, this request must be present. If daily analgesia management is planned in addition to performing an anesthetic, once again it helps to define these two activities as separate and have two providers conduct these activities as separately as possible. Post-operative analgesia management requires the use of specific evaluation and management codes. In addition, E/M code-specific documentation of management by the provider managing the analgesia is required. Even if perfect documentation of the surgeon request is present, separation from anesthesia care is obvious, allowable codes are appropriately used, and the necessity of this activity is documented by providers, payers may deny payment unless the surgeon *also agrees to sever his or her claim to payment for postoperative management of the patient* by submitting request for payment for his care using a 'surgical care only-54' or 'reduced services-52' modifier[11,12]. Management by providers of an acute pain service can best be summarized using the following E/M and consultation codes[13].

Evaluation & Management / Consult Code	Description of activity
01996	Daily continuous neuraxial drug infusion management
99221,99222, 99223	Initial daily hospital care
99231,99232, 99233	Subsequent daily hospital care
99251,99252,99253	Inpatient consultation

Like the use of CPT codes, these E/M codes are associated with the same catergory/site codes as above.

3. **Requirement to use modifiers** in order to bill for more than one regional block for analgesia /per patient, aborted procedures, failed procedures and others:

Like for our surgical colleagues, most payors reimburse for more than one block, aborted attempts, and failed blocks but at a diminished rate of reimbursement. Appropriate modifiers commonly used are summarized as follows (those with asterisk require specific documentation):

CPT Code Modifiers	Description of activity
22*	Increased procedural services for substantial additional work
51	More than one procedure/patient
52*	Request for reduced payment for services: cancelled surgery or failed block
53*	Aborted procedure
76	Repeat procedure on same day, same provider
77	Repeat procedure on same day, different provider
59*	Distinct procedural service (unbundles from anesthesia care)

In addition to the above overview of billing as it relates to professional fees, some institutions have successfully set up practices where the institution bills for the use of a Regional Anesthesia Area using a specifically designed facility fee.

Main References: Portions of this manuscript are reproduced directly from the authors own work:

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