Payment & Practice Management

New Fascial Plane Block Codes

Helen Olkaba, MS Edward R. Mariano, MD, MAS, FASA, FASRA

The long-awaited Fascial Plane Block Current Procedural Terminology (CPT) codes will become available starting January 1, 2025. These new codes will be used to report thoracic, lower-extremity, and abdominal fascial plane blocks for postoperative pain management. Currently, since there are no CPT codes to report anesthetic injections into a fascial plane other than the specific codes for transversus abdominis plane (TAP) blocks, fascial plane blocks administered in other regions are reported using CPT code 64999 *Unlisted procedure, nervous system*. Fascial plane blocks are regional anesthesia techniques in which the space ("plane") between two discrete fascial layers is the target of needle insertion and local anesthetic injection. There has been a rapid expansion of fascial plane block techniques in recent years associated with the routine adoption of ultrasound guidance.

ASA, along with ASRA Pain Medicine, submitted a code proposal to the American Medical Association (AMA) CPT Editorial Panel in September 2023 after months of preparation. After CPT approval, ASA and ASRA Pain Medicine then surveyed their memberships to collect data to develop value recommendations for AMA's RVS Update Committee (RUC). The RUC and the Centers for Medicare & Medicaid Services accepted the valuation proposals recommended by the societies, which resulted in approval for inclusion in the 2025 Medicare Physician Fee schedule.

There are six new codes describing specific anatomy where the blocks may be performed.

CPT Code	Description	RVUs
64466	Thoracic fascial plane block, unilateral; by injection(s), including imaging guidance, when performed	1.50
64467	by continuous infusion(s), including imaging guidance, when performed	1.74
64468	Thoracic fascial plane block, bilateral; by injection(s), including imaging guidance, when performed	1.67
64469	by continuous infusion(s), including imaging guidance, when performed	1.83
64473	Lower extremity fascial plane block, unilateral; by injection(s), including imaging guidance, when performed	1.34
64474	by continuous infusion(s), including imaging guidance, when performed	1.67

Please note that the new codes already include imaging; therefore, imaging codes (e.g., ultrasound) cannot be reported separately. Although the titles for the TAP block CPT codes are unchanged, the 2025 CPT "Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic Somatic Nerves" section subheading has been revised and updated to "Codes 64486, 64487, 64488, 64489 describe injection of an abdominal fascial plane block." This indicates that the TAP block codes starting in 2025 may be used for other abdominal fascial plane blocks other than the TAP or rectus sheath block (e.g., quadratus lumborum block).

For more information about billing these codes, please contact ASA at **CodingHelp@asahq.org**. ■

Helen Olkaba, MS
ASA Director of Payment and Practice Management.

Edward R. Mariano, MD, MAS, FASA, FASRA
Chair, ASA Section on Education and Research, Professor and Vice Chair, Department of Anesthesiology, Perioperative and Pain Medicine, Stanford University School of Medicine, and Chief of Anesthesiology at the Veterans Affairs Palo Alto Health Care System, Stanford, California.
X: @EMarianoMD
IG: @EMarianoMD

From the Front Lines: Hepzato Kit Surgery in Patient with Active Cancer

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with whom I work has learned this over the course of our first dozen cases, and he respects that."

The patients have done well, says Dr. Saksa. "We have seen objective tumor response, if not a complete reversal. We've completed about two dozen cases, so we don't have enough patients to provide statistics, but some of the early imaging studies are encouraging. More importantly, I'm starting to see repeat patients, which is a positive sign because that means the treatment is working. Part of that is because I thoroughly screen all of the patients in a preop clinic before their procedure. It's often over Zoom because many of them are coming from far away. I ask a lot of questions to make sure the patient doesn't have heart disease, a history of strokes, or any bleeding issues in the brain, and that they're not on any blood thinners. We want patients who are healthy, without any other major comorbidities."

"Unfortunately, it's a disease that strikes younger people, so our average patient is in their 50s, but it makes patient selection a little more straightforward than if they were 85," says Dr. Saksa.

Because the procedure is highly specialized and requires advanced training, it is only available at select medical centers that complete a risk evaluation and mitigation strategy (REMS) program administered by Delcath, manufacturer of the Hepzato Kit. The FDA has determined that a REMS is necessary to ensure that the benefits of the procedure outweigh the risks of severe periprocedural complications, including hemorrhage, hepatocellular injury, and thromboembolic events associated with its use. Health care settings must be certified to use the procedure (asamonitor.pub/3BAMBtX).

"It takes a commitment from leadership and clinicians to bring the procedure to your facility," says Dr. Saksa. "UCLA was on board as soon as the FDA approved the treatment. Then we worked with Delcath to get training, which requires observing, shadowing, and proctoring. We visited the facility where some of the research trials had been conducted and observed several procedures. Then, they observed us doing procedures. Now that I've done 10 procedures, I can train, proctor, and mentor others."

He enjoys sharing his experience with other clinicians. "I get these wide-eyed anesthesiologists from other hospitals who are excited about learning this new procedure. I tell them, 'Be prepared, the blood pressure is going to go really low,' but they're never fully prepared for how low it can go. I've seen it go from a systolic BP of 180 to a systolic BP of 70 in one minute, even while I am aggressively supporting the pressure with vasopressors. And that's just the normal anticipated physiologic response to this filtration system; but because we're prepared, and we have the training we have as anesthesiologists, we're the only people in the room that can keep the patient alive at that point."

To ensure the procedure goes smoothly every time, he's collected his learnings into a four-page, single-spaced clinical protocol. "I share it with other clinicians whom I train because it shows exactly how I set up my room, what medications to draw, what steps of the procedure to anticipate, and how to prepare for them. Now we do two of these in a day, and the patients usually go home the next morning with few or no side effects."

The success of this procedure bodes well for attempting other complex procedures outside the OR. "As director of nonoperating room anesthesia, most of my issues are not clinical, they're logistical and operational things. It's about teamwork, safety, and communication," says Dr. Saksa. "It's nice to see a procedure like this where we started together as a multi-disciplinary team, and now we function like a well-oiled machine. It becomes an example of what all non-OR procedural interactions could be like." ■