# Eli's Rehab Report

## Reader Question: Nerve Blocks

**Question:** We have received reductions in payment and denials when billing for multiple levels of nerve blocks using the add-on codes. Is there any way to get paid for the add-on codes at their full rate?

Texas Subscriber

**Answer:** Add-on codes are modifier -51 (multiple procedures) exempt and not subject to reduction. Medicare providers generally do not attempt to reduce payments for add-on codes, though denials may ensue if add-on codes are reported separately from the primary procedure to which they should be attached. Some third-party carriers, however, may reduce fees inappropriately.

Billing 64470 (injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic; single level) with one or more units of 64472 (cervical or thoracic, each additional level) is normally allowable on an invoice. Some providers, however, will erroneously pay the add-on codes at 50 percent of their given profile. You should monitor this very closely and launch an immediate appeal if it occurs.

Also consider that although modifier -51 may not be reported with add-on codes, other modifiers, including -58 (staged or related procedure or service by the same physician during the postoperative period) can be used when all the appropriate criteria are met. If modifiers that should be placed on a claim to indicate a staged procedure or an unrelated procedure (modifier -79) to a previous surgery from which the global period may still be in effect are not added, payment may be denied.

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