SOAP Ad Hoc Committee Labor Epidural Documentation for Billing
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Mission: Documentation for labor analgesia via epidural or other means has little national guidance for best practices. Some members have complained that various insurers are asking for different documentation practices, leading to confusion, difficulties, and wasted effort. Differing documentation may be requested or required by varied legislation, contracts, common local practices or different insurers.

Members currently provide medical management and services associated with epidural management which are generally underappreciated and often undocumented. The Society for Obstetric Anesthesia and Perinatology (SOAP) has developed some general best practices to help provide one documentation standard for labor epidural analgesia.

Obstetric Anesthesia Services Provided:
Management of labor analgesia via epidural or other means requires complex, continual medical management and supervision. The initial medical evaluation and physical placement of an epidural catheter only constitutes the *beginning* of the medical services provided.

Immediately after epidural placement, medical management includes assessment for pain relief, need for additional pain medication, patient safety, cardiovascular stability, response to fetal heart rate changes if hypotensive, degree of motor block, interventions to support cardiorespiratory stability, patient satisfaction, and additional adjustments according to the constantly changing obstetric conditions and obstetric management plan.

While many labor anesthesia services utilize PCEA (patient controlled epidural analgesia) epidural pumps and utilize the patient self-administration programming option (which increases patient satisfaction), the epidural infusion alone does not recognize the multiple medical services simultaneously being provided for that patient. Labor analgesia via epidural requires ongoing assessment, adjustment, immediate availability, and continual medical management and supervision. While some aspects may be performed by protocols (e.g. frequency of vital signs, recording of pain score) by the labor nurse per local hospital policy, the assessments and management of the data and patient are simultaneously being performed by the anesthesia provider.

Continual medical management and monitoring of labor analgesia via epidural are often underappreciated and potentially under-documented, but they always occur. Patients are continually directly and indirectly monitored for hemodynamic stability, degree of pain relief, degree of sensory and motor block, and patient satisfaction. As labor progresses, many aspects

constantly may change including: obstetric medications and dosage changes (e.g. Oxytocin, which by itself increases frequency, strength and thereby pain of contractions), obstetric management changes, maternal position changes related to laboring, fetal heart rate changes, changes in the location and severity of pain as labor progresses - all requiring anesthesia provider interaction, assessment and coordination of care, potentially needing changes to medication dose and strength, and/or epidural infusion.

Continual medical management and monitoring may include discussing the obstetric/medical management plan of care, safety rounds discussing each patient, coordination of care, discussions with the patient's nurse, obstetrician and/or midwife, or other medical consultants involved in the patients care. Anesthesia services may include evaluation and management during periods of fetal heart rate changes which may include trips to the operating room for a potential urgent/emergent cesarean delivery.

Labor analgesia management also currently requires coordinating care and interacting with the patient's labor support team (father of baby, labor coach, friends, family, doula) as part of the patient's integrated, holistic care.

Manually administered epidural medications will vary with patient response, level of anesthesia, location and severity of pain. Based upon the constantly changing obstetric management plan, increases or decreases in the requirement for epidural analgesia may be needed to effectively treat the labor pain during first stage and second stages of labor, post-delivery surgical repair (of the perineum, vaginal vault, cervix, anal sphincter or other), placenta delivery complications, etc.

In the immediate post-delivery period, the patient with epidural analgesia will be monitored or evaluated for post-partum hemorrhage, surgical repair, peri-delivery analgesia and recovery.

<u>Methods of documentation:</u>

Various EMR (electronic medical record) systems and variations within individual EMR systems (e.g. EPIC) also make standardized formatting for epidural labor analgesia documentation quite difficult. Some anesthesia records have vital signs imported directly into the anesthesia record, while many do not. Some labor epidural analgesia anesthesia records are paper records.

As discussed above, the continual medical management and supervision of labor epidural analgesia and anesthesia are varied and complex. SOAP hopes the effort to provide good medical documentation, show the ongoing services being provided, and establishing best practices will reduce billing related documentation variations and difficulties/challenges to payment for services related to documentation.

As a service to all providers of obstetric anesthesia, some suggestions for best practices on labor epidural documentation are listed below.

Suggested Labor epidural documentation best practices:
A brief note may be entered in the medical record (anesthesia record preferred location) for many generally unrecorded aspects of obstetric anesthesia care including but not limited to: patient assessments, rounding, additional adjustments to epidural medications or settings, anesthesia provider administered boluses, resuscitative efforts, safety rounds, discussions about tailoring anesthetic management to the current obstetric management, etc. Part or all of those components of anesthesia services may be documented.

To simplify and assist all providers of obstetric anesthesia, labor epidural documentation best practices may be accomplished by:
Entering a note every 3-4 hours in the medical record.
Suggested wording would include these or similar components:
Rounded on patient. No complaints. Relatively comfortable. No significant motor block. No adjustments needed to epidural at this time.
Also, possible to include:
Discussed patient's coordinated care at patient safety rounds.
Hemodynamically stable.
See Flowsheet for vitals. (if vital are not imported into anesthesia record or can include BP, P and may include pain scores)

Post Delivery Anesthesia documentation includes:
Documentation of Recovery from analgesia/anesthesia. Patient meeting discharge criteria.

A post-anesthesia evaluation by an individual qualified to administer anesthesia within 48 hours after anesthesia services, and the visit should occur after the patient is sufficiently recovered from the acute administration of anesthesia to participate in the evaluation. Elements to be evaluated and documented include cardiovascular status, respiratory status, mental status, temperature, pain, nausea/vomiting and postop hydration. Patient evaluated for adverse sequalae of anesthesia.