COVERAGE:

Intravenous Patient Controlled Analgesia (IV-PCA) is considered medically necessary for management of post-operative pain following major surgical procedures beginning on the first post-operative day and for the medical management of chronic unresponsive cancer pain for hospitalized patients.

IV-PCA should be an itemized part of the facility reimbursement (e.g., the drug, pump/meter, IV hook-up and associated nursing care).

**IV-PCA is also used for;**

- the medical management of chronic cancer pain **AND**
- chronic intractable pain of non-cancerous origin.

Epidural Patient Controlled Analgesia (EPCA) is considered medically necessary for management of post-operative pain following:

- obstetrical procedures
- major surgical procedures involving,
  - organs of the abdomen,
  - spine
  - thoracic cavity,
  - pelvis **OR**
  - lower extremities.

**NOTE: Coverage for Post-Operative Pain Management in the inpatient setting begins on the first Post-Operative day.**

DESCRIPTION:

There are two types of Patient Controlled Analgesia (PCA);

1. **IV-PCA**: the patient pushes a button and self-administers low doses of intravenous narcotic medication via a pump for the relief of pain.

2. **EPCA**: an epidural or intrathecal catheter is inserted, (either by the Anesthesiologist or Surgeon) and local anesthesia or narcotics are used in conjunction with a pump to deliver small doses of the agent directly to the spinal nerves.

With both methods of pain control, the devices are programmed to limit the hourly dosage and intervals between doses to prevent overdosing.
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RATIONALE:

IV-PCA

IV-PCA represents the gold standard in the management of acute pain. The vast majority of studies have documented that IV-PCA is superior to IM injection. A recent meta-analysis, by Ballantyne JC, et al, Journal of Clinical Anesthesia (1993) showed the following results:

• Greater analgesic efficacy with IV-PCA;
• Reduction of opioid usage with IV-PCA;
• IV-PCA was strongly preferred by patients.
• A shorter length of hospital stay; AND
• No significant difference in the incidence of side effects.

EPCA

Patients undergoing abdominal surgery benefit from EPCA in two ways. Patients with upper abdominal incisions, including midline and subcostal incisions, receive markedly better analgesia with epidural infusion of local anesthetic (plus opioid) than systemic analgesia alone. This is especially true in the treatment of active pain. Some patients will not complain of severe pain when lying quietly in bed but will avoid breathing deeply, coughing, and getting out of bed due to intractable pain. EPCA provides relief of active pain for these patients. Another major benefit of epidural analgesia after abdominal surgery is a quicker return of gastrointestinal motility. When patients with EPCA are managed aggressively with early nasogastric tube removal and early feeding, they demonstrate a much faster return to normal bowel function and a decrease in the length of hospital stay. The reasons for these effects are:

• Segmental sympathectomy from EPCA increases peristalsis via enhanced parasympathetic outflow, AND
• Effects of systemic opioid on gastrointestinal mobility are reduced.

Patients undergoing thoracotomy incision often receive epidural analgesia because the excellent pain relief provided is critical for early ambulation and in preserving the ability to cough effectively and breathe deeply. Patients undergoing thoracotomy are at risk for postoperative pulmonary complications, and effective analgesia reduces this risk. EPCA has also been shown to reduce the long-term development of post-thoracotomy pain syndrome.

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Benefits are available for the initial placement of the epidural catheter after general anesthesia, as well as for one (1) visit per post-operative day for up to three (3) post-operative days, by the anesthesiologist or CRNA to monitor the infusion.

If epidural anesthesia is administered for the surgical procedure and the catheter is left in place for post operative pain management. Benefits are available for the once daily post operative visit beginning on the first post-op day, and continuing through the third post-op day. Additional days may be allowed with the establishment of medical necessity.

IV-PCA should be an itemized part of the facility reimbursement (e.g., the drug, pump/meter, IV hook-up and associated nursing care). IV-PCA is not a separate procedure, and all services rendered for IV-PCA are part of the facility charge.

REFERENCES:


Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company
Southwest Texas HMO, Inc.* d/b/a HMO Blue® Texas
* Independent Licensees of the Blue Cross and Blue Shield Association
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DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically. HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general polices and procedures.