



Code Editing Summary Bulletin

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About this Publication

Overview

This publication presents a summary of the edits used by BlueCross and BlueShield of Texas inherent in McKesson's code auditing products along with supporting illustrations.

Audience and purpose

The purpose of the *Code Editing Summary Bulletin* is to familiarize physicians and providers with Blue Cross and Blue Shield of Texas claim editing methodologies including edit definitions with specific examples to illustrate the edit.

This information is supplied to assist physicians and providers in:

- understanding the editing methodology of Blue Cross and Blue Shield of Texas code auditing system
- understanding the coding methodologies, bundling processes, and other policies used to analyze claims for covered services submitted for payment.

Guidelines for use

This publication is intended for use or disclosure solely for the purpose of practice management or billing activities. In accord with the Texas Department of Insurance regulation, this publication *may not* be used to:

- Misrepresent the level of services actually performed
- Determine covered benefits for specific enrollees
- Dictate the types of practices, policies, or procedures that relate to or affect the claims payment process that a health plan may elect to use
- Prescribe, designate, or limit access to medical care

Content overview

Because of the design of Blue Cross and Blue Shield of Texas auditing system, claims are processed efficiently and consistently. The software purchased by BCBSTX developed its editing logic and rules utilizing various industry and government sources. In the edit types cited in this publication, the software makes coding recommendations based on the more than likely scenario and/or the more comprehensive procedure. The code auditing products are not designed to address unusual circumstances that may make an encounter unique. At times, only the appeal and review process can determine when exceptions exist.

Code auditing – industry overview

In the U.S. today, consumers spend more than \$1 trillion annually on healthcare. Unfortunately, many of those dollars are mis-spent because they are lost due to coding inaccuracy, inappropriate billing, and poor administrative practices. These have been major issues impacting the healthcare industry for some time, each of which is addressed by an automated code auditing system.

These automated tools are used by payor organizations to automate their existing medical policies and guidelines to:

- Pay claims appropriately and accurately
- Apply consistent payment policies across providers
- Enhance operational efficiencies and therefore reduce costs
- Decrease claims suspensions and increase processor productivity

Code auditing tools are not designed to establish an organization's medical policy and, therefore, are not independent claims payment tools. Each payor organization is responsible for determining appropriate reimbursement for individual provider claims based on their benefits, coverage, medical, and reimbursement policies.

The health insurance industry has become dependent upon the use of standardized coding systems as the primary mechanism to determine appropriate reimbursement. Much time and effort has been invested in the development of comprehensive coding systems which assign unique "code" numbers to every health care related procedure, service, or product. Reasonable fees or relative value units for each code are determined, turning the coding system into a reimbursement system. This evolution to coding-based reimbursement systems gained increasing momentum over the past 15 years largely due to the obvious advantages it represented in administrative efficiency and health care cost containment.

Our software vendor developed its automated code auditing systems in response to the concerns that the billing code error problem could not effectively be solved through increased education of providers, health insurance claims examiners, and adjudicators. Individual providers or claims examiners could not be expected to provide the high level medical expertise and coding knowledge required to identify and correct all occurrences of billing code error problems. In 2003, the annual coding system updates will include approximately 709 new, 682 revised, and 361 deleted/invalid codes. These annual coding system changes contribute to code error problems that can be supported by code auditing systems.

Providers are responsible for determining the codes that best describe the health care products or services provided. A claim can be coded properly from the standpoint of coding guidelines and still represent a procedure or service that should not be reimbursed. The introduction to the Current Procedural Terminology (CPT) manual published by the American Medical Association even states, “Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.” Each payor has unique reimbursement guidelines that are utilized to determine eligibility for reimbursement.

Code auditing systems are designed to assist data entry clerks, claims examiners, and medical coders in the submission and processing of health care encounters and claim forms. These systems utilize specialized knowledge bases and software that allow users to apply clinical rules and guidelines that assure adherence to industry standards with regard to the appropriate billing of healthcare services and procedures.

Health care payors and providers use code auditing systems to increase productivity, assure accurate and appropriate claims payment on a timely basis, and reduce administrative costs. These benefits accrue directly to the health care consumer who would otherwise bear additional costs. Specifically, when automated code auditing tools are used to assure accurate and appropriate payment, control is maintained over potentially inappropriate payments, manual intervention is eliminated, and claims are paid consistently and promptly.

Clinical knowledge base development policy

The clinical knowledge base, containing the edits, reflects the current state of health care delivery supported by fact and science. Evaluation of external and internal resources of input, including relevant, internally derived data, is completed to develop the knowledge base. The clinical knowledge base supports correct coding and utilization initiatives, while minimizing manual handling and rework.

Sources of information used are reputable references from generally recognized and authoritative materials including, but not limited to:

- “Current Procedural Terminology” (CPT)

- Specialty society coding guidelines
- Medicare Correct Coding Initiative

Overriding considerations, during code edit development, include determination of the most likely clinical scenario and determination of the most clinically intense procedure (e.g., to determine a primary vs. secondary procedure submitted on a claim).

The clinical knowledge bases are developed to allow for easily referenced edits, reinforce correct coding, and minimize administrative burden.

The code auditing systems are designed with customization utilities that allow organizations to manage the knowledge base content.

What's in this publication?

The *Code Editing Summary Bulletin* contains the following section for your review.

Section	Title	Description
1	<i>ClaimCheck</i>	Edit definitions, examples, and edit explanations presented for ClaimCheck.

To obtain help and submit suggestions

Contact Blue Cross and Blue Shield of Texas for assistance using any of the following methods:

- **E-mail:** hcm_medical@bcbstx.com
- **FAX:**
Pre-Service Allowed Benefit Disclosure Request
972-766-0371
- **Correspondence:**
Pre-Service allowed Benefit Disclosure Request
PO Box 650489
Dallas, Texas 75268-0489

1 – ClaimCheck[®]

Overview

ClaimCheck is a clinically based, expert software system that evaluates claim information to detect coding irregularities, conflicts, or errors and makes recommendations for correction.

ClaimCheck uses rule-based logic to:

- Assess provider claims information including CPT/HCPCS procedure codes against a series of edit programs.
- Recommend CPT/HCPCS procedure codes. Payor payment is based on the recommended code. The integrity of the claim is not altered.

In this section

This section contains information on the ClaimCheck edits.

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Structure

For each ClaimCheck edit presented in this section, information is organized as follows:

Edit name	Identifies the edit type
Definition	Defines the edit
Example	Example to demonstrate the edit
Code(s) Code description(s) Status	<ul style="list-style-type: none"> • CPT/HCPCS procedure code(s) • Description of the procedure code(s) • Indicates the status of each procedure in the example: <i>Allow/Disallow/Review</i>
Explanation	Explains the procedure's "Status" in the example.

Age conflict

Definition:

The Age Conflict edit occurs when an age-specific procedure code is assigned to a patient whose age is outside the designated age range for that procedure.

Example:

Code	Description	Status
19030	Injection procedure only for mammary ductogram or galactogram	Disallow

Explanation:

- Procedure 19030 is submitted for a 10 year-old patient.
- Procedure 19030 is an adult procedure; age should be over 14 years.
- Procedure 19030 receives an error status message, indicating an error in the claim information.

Alternate code recommendation

Definition:

The Alternate Code Recommendation edit identifies an “alternate” procedure code that will be recommended for addition to a claim when a discrepancy is detected between a submitted procedure code and the patient’s age or gender relative to that procedure code. Payment is based on the appropriate code, the claim integrity is not altered.

Example 1:

Code	Description	Status
42825	Tonsillectomy, primary or secondary; under age 12	Disallow
42826	Tonsillectomy, primary or secondary; age 12 or over	Allow

Explanation:

- Procedure 42825 is submitted for a 16 year-old patient.
- Procedure 42825 is used to report the intraoral surgical removal of the tonsils for a patient less than 12 years of age.
- Procedure 42826 is recommended as a replacement for 42825 as the correct procedure code for a patient age 12 and over.

Example 2:

Code	Description	Status
53600	*Dilation of urethral stricture by passage of sound or urethral dilator, male; initial	Disallow
53660	*Dilation of female urethra including suppository and/or instillation; initial	Allow

Explanation:

- Procedure 53600 is submitted for a female patient.
- Procedure 53600 is used to report the dilation of urethral stricture by passage of sound or urethral dilator for a male patient.
- Procedure 53660 is recommended as a replacement for procedure code 53600 as the correct procedure code for a female patient.

Assistant at Surgery

Definition:

The Assistant Surgeon edit identifies procedures not requiring an assistant-at-surgery.

Example:

Code	Description	Status
67311-80	Strabismus surgery, recession or resection procedure; one horizontal muscle	Disallow

Explanation:

- Procedure 67311 indicates that the eye has not previously been operated on. After an incision is made in the conjunctiva, dissection of the medial or lateral rectus muscle is accomplished.
- Procedure 67311 is not sufficiently complex or extensive to warrant an assistant surgeon.

Cosmetic

Definition:

The Cosmetic edit identifies a procedure that is typically performed for cosmetic reasons. Cosmetic determination is made based on member contract and Medical Policy.

Example:

Code	Description	Status
11200	*Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	Review

Explanation:

- Procedure 11200 is used to report removal of up to fifteen (15) fibrocutaneous skin tags on any area of the body. Removal can be performed by scissoring or any sharp method, ligature strangulation, electrosurgical destruction or combination of treatment modalities including chemical or electrocauterization of the wound. Local anesthesia may be used.
- Procedure code 11200 may be a cosmetic procedure and a review of additional information is recommended.

Duplicate

Definition:

A Duplicate edit occurs when a procedure code description contains terminology that does not warrant multiple submissions of that procedure for a single date of service.

This includes the following terms:

- Bilateral
- Unilateral/bilateral
- Single/multiple

A Duplicate edit also occurs when a procedure is submitted multiple times, exceeding the maximum allowance that would be clinically appropriate.

Example 1:

Code	Description	Status
76092	Screening mammography, bilateral (two view film study of each breast)	Allow
76092	Screening mammography, bilateral (two view film study of each breast)	Disallow

Explanation:

- Procedure 76092 is performed to detect unsuspected cancer and is inherently bilateral.
- Procedure code 76092 is a bilateral code and the duplicate submission of the procedure code is not warranted.

Example 2:

Code	Description	Status
47600	Cholecystectomy;	Allow
47600	Cholecystectomy;	Disallow

Explanation:

When the procedure 47600 is submitted a second time on a single date of service, it is not warranted as this procedure can only be performed once in a patient's lifetime.

Example 3:

Code	Description	Status
29805-RT	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	Allow
29805-LT	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	Allow
32440-RT	Removal of lung, total pneumonectomy;	Disallow
32440-LT	Removal of lung, total pneumonectomy;	Allow

Explanation:

- Procedure 29805 is used to report a diagnostic shoulder arthroscopy. This procedure can be performed once per side on a single date of service. Therefore, both submissions of the code would have the “allow” status.
- Procedure 32440 is used to report the removal of an entire lung. When submitted twice on a single date of service, the second submission of the procedure code is not warranted based on a determination that it is not clinically appropriate.

Example 4:

Code	Description	Status
26250-F1	Radical resection, metacarpal; (e.g., tumor)	Allow
26250-F1	Radical resection, metacarpal; (e.g., tumor)	Disallow

Note: -F1 modifier, left hand, second digit

Explanation:

Procedure 26250 is used to report radical resection of the metacarpal. Although the procedure code is valid with modifier -F1, the procedure can be performed only once per date of service based on a determination of clinical appropriateness. Therefore, the second submission of procedure 26250-F1 is not recommended.

Example 5:

Code	Description	Status
80055	Obstetric panel: this panel must include the following: hemogram, automated, and manual differential WBC count (CBC) (85022) or hemogram and platelet count, automated, and automated complete differential WBC count (CBC) (85025) hepatitis B surface antigen (HBSAG) (87340) antibody, rubella (86762) syphilis test, qualitative (e.g. , VDRL, RPR, ART) (86592) antibody screen, RBC, each serum technique (86850) blood typing, ABO (86900) and blood typing, RH (D) (86901)	Allow
80055	Obstetric panel: this panel must include the following: hemogram, automated, and manual differential WBC count (CBC) (85022) or hemogram and platelet count, automated, and automated complete differential WBC count (CBC) (85025) hepatitis B surface antigen (HBSAG) (87340) antibody, rubella (86762) syphilis test, qualitative (e.g. , VDRL, RPR, ART) (86592) antibody screen, RBC, each serum technique (86850) blood typing, ABO (86900) and blood typing, RH (D) (86901)	Review

Explanation:

Procedure 80055 is an obstetric panel. When submitted more than once on a single date of service, a review of documentation may be required to substantiate the performance of the duplicate obstetric panel.

Evaluation and management services

Definition:

One (1) type of edit is associated with evaluation and management services:

- Global surgery period

Global surgery

Procedures that are assigned a 90-day global surgery period are designated as *major* surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as *minor* surgical procedures.

- Evaluation and management services (90-day), submitted with major surgical procedures, (1-day) pre-operatively, on the same date of service or during the 90-day post-operative period, are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services (10-day), submitted with minor surgical procedures, (10-day) on the same date of service or during the 10-day post-operative period, are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted for “established” patients with minor surgical procedures (0-day), are not recommended for separate reporting on the same date of service because they are part of the global service and because there is an inherent evaluation and management service component included in all surgical procedures. This guideline also applies for submitted evaluation and management services that do not differentiate between “new” or “established” patients in the procedure code description.
- Services submitted for a “new” patient visit or an “initial” patient visit typically exceed services included in 0-day surgical procedures. Therefore, separate reporting of evaluation and management services for new patients or initial patient visits is recommended.

Example 1 (global surgery):

Code	Description	Status
69000 DOS=05/20/0 2	*Drainage external ear, abscess or hematoma; simple	Allow
99213 DOS=05/24/0 2	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coord of care w/ other providers or agencies are provided consistent w/ nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/ patient &/or family.	Disallow

Explanation:

- Procedure 69000 (10-day global surgery period) is used to report simple drainage of an abscess or hematoma of the external ear.
- Procedure 99213 is used to report an evaluation and management service provided to an established patient during an outpatient office visit.
- When a minor surgical procedure is performed, the evaluation and management service is included in the global surgical period.

Notes: Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

Modifier -79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When these modifiers are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service may be allowed.

Gender conflict

Definition:

The Gender Conflict edit occurs when a gender-specific procedure code is incorrectly assigned based on the gender of the patient referenced on the claim.

Example:

Code	Description	Status
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	Review

Explanation:

- Procedure 58150 is submitted for a male patient.
- Procedure 58150 is used to report the removal of the uterus and cervix and one or both ovaries and one or both of the fallopian tubes.
- Procedure 58150 is not indicated for a male.
- Procedure 58150 receives an error status message indicating an error between the code and the claim information.

Incidental

Definition:

The Incidental edit identifies a procedure(s) that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

Example:

Code	Description	Status
25101	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body	Allow
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	Disallow

Explanation:

- Procedure 25101 involves a surgical incision into the wrist joint for the purpose of exploration. The joint is thoroughly explored and a biopsy may be taken. This procedure also includes the removal of loose or foreign bodies when indicated.

- Procedure 64721 includes the decompression or freeing of the median nerve from scar tissue, including external neurolysis and/or transposition. The components of this procedure are utilized in the treatment of carpal tunnel syndrome.
- When the performance of neuroplasty decompression or the freeing of an intact nerve is reported with a more comprehensive surgical procedure of the upper extremity, it is considered an integral component of the primary procedure and necessary for the successful outcome of that procedure.

Modifiers

Definition:

Edits exist for procedures that are submitted with the following modifiers:

- **-80, -81, -82, -RT, -LT, E1-E4, FA-F9, TA-T9, -LC, -LD, and -RC.**

Modifier	Description	Edit Definition
-80,-81,-82	Assistant Surgeon	Refer to “Assistant surgeon” example.
-RT -LT	<ul style="list-style-type: none"> • Right side of body • Left side of body 	Refer to “Duplicate” example.
E1-E4, FA-F9, TA-T9, -LC,-LD,-RC	Eyelids, digits, fingers, phalanges, carpals, metacarpals, toes, tarsals, metatarsals, left circumflex artery, left anterior descending artery, right coronary artery	Refer to “Duplicate” example.
-26 -TC	<ul style="list-style-type: none"> • Professional Component • Technical Component 	Refer to “Duplicate example.”

Mutually exclusive

Definition:

The Mutually Exclusive edit identifies combinations of procedures that differ in technique or approach but lead to the same outcome. This includes: a combination of procedures that may be anatomically impossible; represent overlapping and/or duplication of services; or are reported as both an initial and subsequent service. Generally, an open surgical procedure and closed procedure in the same anatomic site will be mutually exclusive.

Example:

Code	Description	Status
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	Allow
58260	Vaginal hysterectomy;	Disallow

Explanation:

- Procedure codes 58150 and 58260 are submitted on a claim.
- Procedures 58150 and 58260 are considered mutually exclusive because both procedures accomplish the same clinical outcome, using different approaches.
- Procedure 58150 is recommended for separate reporting because it is the more clinically intense procedure.

Obsolete

Definition:

The Obsolete edit identifies a procedure that is no longer performed under prevailing medical standards.

Example:

Code	Description	Status
30210	*Displacement therapy (Proetz type)	Review

Explanation:

- Procedure 30210 is no longer performed under prevailing medical standards and is considered obsolete. When submitted, this procedure is flagged for review.

Rebundling

Definition:

The Rebundling edit identifies procedure unbundling, which occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that represents the service submitted.

To correct this type of coding error, the unbundled procedure code(s) is rebundled to the comprehensive procedure code.

Occasionally, the procedure code that most accurately represents the services submitted will be recommended as an alternate code. Payment is based on the appropriate code, the claim integrity is not altered.

Example 1:

Code	Description	Status
42821	Tonsillectomy and adenoidectomy; age 12 or over	Allow
42826	Tonsillectomy, primary or secondary; age 12 or over	Disallow

Explanation:

- Procedure 42821 describes the surgical removal of the tonsils and adenoids for a patient age 12 and older.
- Procedure 42826 is the same as that described above for removal of tonsils, only no adenoidectomy is performed.
- Procedure 42821 includes both the tonsillectomy and the adenoidectomy and more accurately describes the complete service performed.

Example 2:

Code	Description	Status
27705	Osteotomy; tibia	Disallow
27707	Osteotomy; fibula	Disallow
27709	Osteotomy; tibia and fibula	Allow

Explanation:

- Procedure 27705 is used to report an osteotomy of the tibia. Following incision and exposure of the bone, proper alignment of the bone is achieved by a cut that is made through the tibia. Fixation by screws or plates may be applied to maintain position.
- Procedure 27707 is used to report an osteotomy of the fibula. Following incision and exposure of the bone, proper alignment of the bone is achieved by a cut that is made through the fibula. Fixation by screws or plates may be applied to maintain position.
- Procedure 27709 is used to report an osteotomy of the tibia & fibula. This procedure represents the comprehensive procedure and is recommended on the claim.

Unlisted

Definition:

The Unlisted review flag identifies procedure codes that include the word, “unlisted”, in the procedure code description. Unlisted procedure codes should not be used when a more descriptive procedure code representing the service provided is available.

Example:

Code	Description	Status
21499	Unlisted musculoskeletal procedure, head	Review

Explanation:

- Procedure 21499 is an unlisted musculoskeletal procedure of the head.
- A review of additional information is recommended when this procedure code is submitted to validate that a more accurate procedure code to describe the service provided is not available.