



# Code Editing Summary Bulletin

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Version 3.0

DECEMBER 6, 2004

Blue Cross and Blue Shield of Texas utilizes McKesson Information Solutions code auditing software, that serves as one of the sets of guidelines for coverage decisions. Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the auditing tool. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to all applicable state and/or federal law. The auditing tool does not constitute plan authorization, nor is it an explanation of benefits.

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**Publication date**

Edition, September 2004  
Printed in U.S.A.

**U.S. Patent Number**

5,253,164

**Version**

Code Editing Summary Bulletin – Version 3.0

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**McKesson publication number**

Document ID: CESB030904

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## About this Publication

### Overview

This publication presents a summary of the edits inherent in McKesson's code editing products along with supporting illustrations.

### Audience and purpose

The purpose of the *Code Editing Summary Bulletin* is to familiarize physicians and providers with McKesson's 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 the McKesson code editing systems

understanding the coding methodologies, bundling processes, and downcoding 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



In addition, this publication may not be used to prescribe, designate, or limit access to medical care create, attempt to create, or permit others to create derivative works

## Content overview

Because of the design of McKesson's code editing products, claims are processed efficiently and consistently. McKesson develops its editing logic and rules utilizing various industry and government sources. In the edit types cited in this publication, McKesson makes coding recommendations based on the more than likely scenario and/or the more comprehensive procedure. The code editing 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 editing – 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 editing 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
- Improve the turnaround time of reimbursement to providers
- Enhance operational efficiencies and demonstrate cost management savings
- Decrease claims suspensions and increase processor productivity

Code editing 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.

McKesson developed its automated code editing 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 editing systems.

Providers are responsible for determining the codes that best describe the health care products or services provided. With respect to improperly coded claims, 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 services eligible for reimbursement.

Code editing 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 editing 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 editing 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 (i.e., claims data), is completed to develop the knowledge base and verify the most likely clinical scenario present on a claim. The clinical knowledge base supports correct coding and utilization initiatives, while minimizing manual handling and rework.

Additionally, the clinical knowledge base is reviewed on an ongoing basis to ensure accuracy regarding the interpretation of codes, coding conventions, and modifiers. Regular feedback from medical directors and claims administrators within the customer base is an integral step in the knowledge base development process.

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

“Current Procedural Terminology” (CPT)

CPT Assistant

CPT Coding Symposium

Specialty society coding guidelines

Medicare Guidelines

When ambiguities in CPT are identified, clarification is sought through correspondence with the AMA’s Department of Coding and Nomenclature, which provides guidance and insight to changes in the CPT classification system.

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 editing systems are designed with customization utilities that allow organizations to manage the knowledge base content to ensure that it reflects unique coding requirements, reimbursement guidelines, and medical policy.



## 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](mailto: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<sup>®</sup>

## Overview

ClaimCheck is a clinically based, expert software system that evaluates claim information. A knowledge base that includes a comprehensive set of data and rules functions in conjunction with the software to assist users in automating correct coding and medical policy decisions and to detect coding irregularities, conflicts, or errors making recommendations for correction.

ClaimCheck uses clinically-based rules 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.

### 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	<b>Identifies the edit type</b>
Definition	<b>Defines the edit</b>
Example	<b>Example to demonstrate the edit</b>
Code(s) Code description(s) Status	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	<b>Explains the procedure's "Status" in the example.</b>

## 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	<b>Injection procedure only for mammary ductogram or galactogram</b>	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.

### Example 1:

Code	Description	Status
42825	<b>Tonsillectomy, primary or secondary; under age 12</b>	Disallow
42826	<b>Tonsillectomy, primary or secondary; age 12 or over</b>	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	<b>*Dilation of urethral stricture by passage of sound or urethral dilator, male; initial</b>	Disallow
53660	<b>*Dilation of female urethra including suppository and/or instillation; initial</b>	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 surgeon

**Definition:**

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

Many surgical procedures require aid in prepping and draping the patient, maintaining visualization, keeping the wound clear of blood, holding and positioning the patient, assisting with wound closure, and dressing and/or casting, if required. This assistance does not require the surgical expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide it.

**Example:**

Code	Description	Status
11720-80	Debridement of nail(s) by any method(s); one to five	Disallow

**Explanation:**

Procedure 11720 is used to report the removal of devitalized tissues from the fingernails or toenails. Nails are shortened and shaped following manually cleaning with abrasive materials and tools.

Procedure 11720 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 the member contract and Medical Policy.

### Example:

Code	Description	Status
11200	<b>*Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions</b>	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:**

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

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

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-F1 modifier, left hand, second digit

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**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:**

<b>Code</b>	<b>Description</b>	<b>Status</b>
80055	<b>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)</b>	Allow
80055	<b>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)</b>	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:

Two (2) types of edits are 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, submitted with *major* (90-day) 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, submitted with *minor* (10-day) surgical procedures 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 (0-day) surgical procedures 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	<b>*Drainage external ear, abscess or hematoma; simple</b>	Allow
99213 DOS=05/24/0 2	<b>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 &amp; coord of care w/ other providers or agencies are provided consistent w/ nature of problem(s) &amp; patient's &amp;/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/ patient &amp;/or family.</b>	Disallo w

**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	<b>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);</b>	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	<b>Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body</b>	Allow
64721	<b>Neuroplasty and/or transposition; median nerve at carpal tunnel</b>	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.**

<b>Modifier</b>	<b>Description</b>	<b>Edit Definition</b>
<b>-80,-81,-82</b>	Assistant Surgeon	Refer to "Assistant surgeon" example.
<b>-RT</b> <b>-LT</b>	<ul style="list-style-type: none"> <li>• Right side of body</li> <li>• Left side of body</li> </ul>	Refer to "Duplicate" example.
<b>E1-E4,</b> <b>FA-F9,</b> <b>TA-T9,</b> <b>-LC,-LD,-RC</b>	Eyelids, digits, fingers, phalanges, carpals, metacarpals, toes, tarsals, metatarsals, left circumflex artery, left anterior descending artery, right coronary artery	Refer to "Duplicate" example.
<b>-26</b> <b>-TC</b>	<ul style="list-style-type: none"> <li>• Professional Component</li> <li>• Technical Component</li> </ul>	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	<b>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);</b>	Allow
58260	<b>Vaginal hysterectomy;</b>	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 comprehensive services submitted will be recommended as an alternate code to be added to the claim.

### Example 1:

Code	Description	Status
42821	<b>Tonsillectomy and adenoidectomy; age 12 or over</b>	Allow
42826	<b>Tonsillectomy, primary or secondary; age 12 or over</b>	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:**

<b>Code</b>	<b>Description</b>	<b>Status</b>
27705	<b>Osteotomy; tibia</b>	Disallow
27707	<b>Osteotomy; fibula</b>	Disallow
27709	<b>Osteotomy; tibia and fibula</b>	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 to be added to 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.