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Part B Insider (Multispecialty) Coding Alert

READER QUESTION: Know the Differences Between 'Mutually Exclusive' And 'Bundled' Procedures

The differences could affect your reimbursement.

Question: Can you explain what the differences are between mutually exclusive and "column 1/column 2" edits that come from the Correct Coding Initiative (CCI)?

Answer: Mutually exclusive edits pair procedures or services that the physician could not reasonably perform at the same session on the same beneficiary.

For example, CCI lists 61312 (Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural) as mutually exclusive of 61313 (...intracerebral). The payer would not expect that the doctor would perform both types of craniectomy on the same date for the same patient because they describe different, exclusive procedures.

Bottom line: If you were to report two mutually exclusive codes for the same patient during the same session, Medicare would reimburse only for the lesser-valued of the two procedures (in the case of 61312 and 61313, the payer would reimburse only 61312).

Column 1/column 2 edits describe "bundled" procedures. That is, CMS considers the procedure code listed in column 2 as the "lesser" service, which is included as a component of the more extensive, column 1 procedure code.

Example: The CCI contains an edit bundling 61535 (Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue [separate procedure]) with 61320 (Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial).

In this case, 61320 is the more extensive procedure which includes the "lesser" procedure 61535. In theory, removing the electrode array is not significant enough to warrant separate payment when it's done at the same time as the abscess drainage.

Bottom line: If you were to report bundled (column 1/column 2) procedures for the same patient during the same session, Medicare would reimburse only for the highervalued of the two procedures (in the case of 61320 and 61535, the payer would reimburse only 61320).