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## CODING CORNER

### AAP Division of Health Care Finance and Practice

*I've noticed that some carriers are bundling certain services into well-child visits and are not reimbursing separately for them. What can I do about this?*

CPT guidelines indicate that services that are identified with specific codes should be reported separately from any other code. Therefore, they should not be "bundled" into any other code(s).

This concept is found throughout CPT guidelines. Some examples include:

- Preventive medicine services: "Immunizations and ancillary studies involving laboratory, radiology, other procedures *or* screening tests identified with a specific CPT code are reported separately" (*CPT 2004* {professional edition}, page 30).
- Vision screening: "Other identifiable services unrelated to this screening test provided at the same time may be reported separately (i.e., preventive medicine services)" (*CPT 2004*, {professional edition}, page 372).
- Modifier–25: "The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed" (*CPT 2004* {professional edition}, page 381) and "If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing a preventive medicine service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier–25 should be appended to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service" (*CPT 2004* {professional edition}, page 30).

Many carriers are unaware that they are violating CPT guidelines when they inappropriately bundle two services when each of the involved services has a separate CPT code.

The aforementioned CPT guidelines are applicable to other screening tests or procedures that are identified with a specific CPT code, such as audiometry, intramuscular injection of antibiotics, immunization administration or cerumen removal. Physicians are correct in reporting such services separately from any accompanying E/M service.

While no legal mandate requires private carriers to adhere to CPT guidelines, it is considered a "good faith" gesture for them to do so, given that the guidelines are the standard within organized medicine. Separately reportable services that are not recognized by a carrier should be designated non-covered benefits and billable to the patient.

*If carriers are not reimbursing you for services you are coding appropriately, contact Lou Terranova, AAP Division of Health Care Finance and Practice, at [lterranova@aap.org](mailto:lterranova@aap.org) or call (800) 433-9016, ext. 7633.*