

*Kansas Breastfeeding Coalition*  
*June 9, 2020*

# Insurance Payment for Lactation Services in the Practice Setting

# AGENDA



## MAKING SENSE OF THE LAW & CREDENTIALING

- How are Insurers lactation services?
- Who can be paid and why?



## CODING & BILLING

- How to effectively code and bill for services
- Payer Policies



*Sources include AAP, Payer Policies direct from Payer websites, KanCare*



# THE LAW, BENEFITS & LICENSURE



# The Current Situation

*“I’ve continued to feel frustrated that we are not offering/billing all of the “free lactation support” parents are supposed to receive through the ACA- as well as undervaluing our profession. To get coverage, I generally see all of my patients for the majority of the visit ( both for newborn physicals and wt check/feeding support follow up visits) in conjunction with a physician or nurse practitioner who comes in more briefly- so we can bill an “up” charge for the visit, as opposed to just a nurse visit if I saw them alone.”*

***Why is this the reality that many lactation consultants despite the fact that the ACA law went into effect nearly a decade ago?***

# Affordable Care Act: Prevention Coverage for Women's Health: Breastfeeding support, supplies, and counseling

The law states that Payers must cover, at no cost to the patient, "comprehensive lactation support and counseling, by a trained provider during pregnancy and / or in the postpartum period, and costs for renting breastfeeding equipment".

But how are these terms being defined?

- What is “comprehensive lactation support & counseling”?
- Who qualifies as a “trained provider”?

The law is vague and has allowed for multiple interpretations on WHO gets Paid and WHAT codes get paid.

# Insurers' Interpretation of the Law

The vagueness regarding coverage allows Payers to determine policies for paying the benefit

- The law does not mandate WHO gets paid for providing those services or how
  - In-hospital services are bundled into the delivery payment
  - Providers already contracted to a Payers' existing network (e.g. physicians and mid-levels (NPs, PAs)) are often the only paid providers, though they are not specifically trained in lactation

# The Law and Patient Benefits

Each Insurer is covering benefits differently

- Example: Aetna vs. United Healthcare
  - Aetna contracts with IBCLCs; covers up to 6 consults
  - UHC does not contract with IBCLCs; it uses its existing network of licensed providers;
    - may cover out-of-network IBCLCs and other providers solely dependent upon the patient's benefits (driven by employer)

# The Law and Patient Benefits

## Patient Benefits Can Vary Within the Same Plan

- ◆ Two patients with the same insurance may have different benefits
- ◆ An insurer may have a policy that states HOW lactation benefits get paid, but that can vary depending upon the ‘plan sponsor’



# Patient Benefit Design

- ◆ Benefits are typically determined by need, access, regulation
- ◆ Benefits are also 'designed' based on employer needs and demands
- ◆ Many large employers are 'self-funded' versus smaller purchasers who pay premiums so that insurers are the ones 'at- risk'
  - 'Self-funded' means that an employer uses the insurance to process and pay claims and the insurer charges back the exact cost plus a profit for that service
  - 'At-risk' means that the insurer charges a set rate for premiums and takes on the risk if claims costs are higher than what was paid in premiums

# The Law and Patient Benefits

- ◆ Government programs (Medicaid plans)

Medicaid programs operate at the State level. One state may not be doing things the same as another

- ◆ All the Rest

Each Insurer is doing it differently. There is a wide range of policies across Insurers.

# Why Don't Insurers Credential and Contract with All IBCLCs and other trained Lactation Consultants?

- ◆ Very few insurers will credential and contract with **non-licensed providers** (or providers that have licenses that are not MD, DO, DDS, APRN, etc.)
- ◆ The “credentialing” process is an industry-standard systematic approach to the collection and verification of an applicant’s professional qualifications.
- ◆ The National Committee on Quality Assurance (NCQA) sets many of these requirements.
- ◆ Payers **MUST** adhere to these standards **BUT** many Payers confuse credentialing standards with the ability to **PAY** non-credentialed providers . . .

# Types of Providers

The Provider Types that are typically paid for services by Payers are categorized as follows:

- Physicians
- Licensed Non-Physician Providers (typically NPs, PAs, CMWs etc)
- Qualified Healthcare Professionals (licensed and non-licensed)
- Allied Health Providers (typically MAs, technicians, therapists)

# What Is A Qualified Health Care Professional

## From Current Procedural Terminology, (AMA CPT)

“A physician or **“other qualified health care professional”** is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

### **Clinical staff are defined as:**

A clinical staff member is a person who works under the direct supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but does not individually report that professional service. (e.g. MA's, LPNs, technicians)

# Why Don't Payers View IBCLCs as QHCPs?

## Licensure!

- ◆ Other "qualified healthcare professionals" typically include physician assistants, nurse practitioners, certified registered nurse anesthetists, and physical, speech, occupational, and massage therapists.
- ◆ All have demonstrated skill and expertise in their field of study to complete the education and regulatory requirements, to obtain licensure, and to remain in good standing with the respective licensing boards.
- ◆ **Lack of licensure for IBCLCs is causing many of the problems experienced with insurance companies today.**

# In Addition to Laws and Policies governing Benefits, there are also Coding Policies

- ◆ Insurers that pay for lactation services also have coding and medical policies that determine how claims get paid
  - ◆ What CPT code is used?
  - ◆ What diagnosis code is used?
  - ◆ What services are provided?
  - ◆ Services provided in what setting?



# CODING & BILLING





# CPT Codes: Primary Codes for BF Support

- ◆ The American Medical Association (AMA) has developed specific CPT codes intended for use by qualified health care professionals who are not Physicians to report their services. In some instances the intended use of a procedure or service is within the description of the code.
- ◆ For example CPT 98960 describes "education and training for patient self-management" by a "qualified, non-physician health care professional".
- ◆ In other instances the AMA has included parenthetical information in the CPT book as with CPT 96040 which says “These services are provided by trained genetic counselors and may include obtaining a structured family genetic history, pedigree construction, analysis for genetic risk assessment, and counseling of the patient and family.”

# Billing for Services

Every encounter needs to be coded with an appropriate CPT (procedure) code and a corresponding ICD (diagnosis) code.

Example:

Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure):

- 99402 PREVENT MED COUNSEL&/RISK FACTOR, 30 mins

Plus

- P92.9 FEEDING PROBLEM OF NEWBORN

But that's enough to get you paid . . .

# How Are Claims Paid?

- ◆ **Policies** determine what gets paid, to whom, and how
- ◆ Policies define criteria for coverage (payment) and it is this 'logic' that is used to set up claims algorithms in complex claims engine databases
- ◆ Claims engines are also required to follow certain rules with regard to things like modifiers and bundling, usually National Correct Coding Initiative Edits (NCCI Edits)
- ◆ **Every insurance company gets to set it's own policies**

Preventive Coverage Category	Associated CPT/HCPSC Code(s)	Covered preventive diagnoses
<b>Lactation classes, non-physician provider, per session</b>	S9443	Covered as preventive for any diagnosis
<b>Preventive medicine, individual counseling</b>	99401- 15 min 99402 – 30 min 99403 – 45 min 99404 – 60 min +	ICD-9 Codes considered preventive for this category: <ul style="list-style-type: none"> <li>• pregnancy (640.00-677, V22-V24.2, V27-V28.9)</li> <li>• lactation (676.44, 676.54, 676.84, V24.1)</li> <li>• feeding problem in newborn (779.3, 783.3)</li> </ul>
<b>Preventive medicine, group counseling</b>	99411- 30 min 99412 – 60 min	ICD-9 Codes considered preventive for this category: <ul style="list-style-type: none"> <li>• pregnancy (640.00-677, V22-V24.2, V27-V28.9)</li> <li>• lactation (676.44, 676.54, 676.84, V24.1)</li> <li>• feeding problem in newborn (779.3, 783.3)</li> </ul>
<b>Office or outpatient visit for evaluation and management (E&amp;M) – New Patient</b>	99201-99203 Codes determined by time, complexity and review of systems	ICD-9 Codes considered preventive for this category: <ul style="list-style-type: none"> <li>• lactation (676.44, 676.54, 676.84, V24.1)</li> <li>• feeding problem in newborn (779.3, 783.3)</li> </ul>
<b>Office or outpatient visit for evaluation and management (E&amp;M) – Established Patient</b>	99211-99214 Codes determined by time, complexity and review of systems	ICD-9 Codes considered preventive for this category: <ul style="list-style-type: none"> <li>• lactation (676.44, 676.54, 676.84, V24.1)</li> <li>• feeding problem in newborn (779.3, 783.3)</li> </ul>

## Expanded Women's Preventive Health

*These are the requirements of Health and Human Services for plan years that begin on or after 8/1/12.*

*For additional services covered for women, see the Preventive Care Services table above.*

*Certain codes may not be payable in all circumstances due to other policies or guidelines.*

Note:  
The codes are for classes, consultations or home visits.

There are no office-based non-referred codes or counseling codes like 99401-99404

AND . . .

Service:	Code(s):	Claims Edit Criteria:
<p><b>Breastfeeding Support, Supplies, and Counseling</b></p> <p>HHS Requirement: Breastfeeding support, supplies, and counseling: Comprehensive lactation support and counseling, from a trained provider, during pregnancy and/or in the postpartum period, and costs for renting <b>breast</b>feeding equipment, in conjunction with each birth.</p>	<p><b>Support and Counseling:</b> <b>Procedure Code(s):</b></p> <ul style="list-style-type: none"> <li>• S9443</li> <li>• 99241, 99242, 99243, 99244, 99245</li> <li>• 99341, 99342, 99343, 99344, 99345</li> <li>• 99347, 99348, 99349, 99350</li> </ul> <p>Also see the codes in the <b>Wellness Examinations</b> section of the Preventive Care Services table above.</p> <p><b>Diagnosis Code(s):</b></p> <ul style="list-style-type: none"> <li>• <u>ICD-9</u>: V24.1</li> <li>• <u>ICD-10</u>: Z39.1</li> </ul> <p><b>Breast Pump Equipment &amp; Supplies:</b> <b>Procedure Code(s):</b></p> <p><i>Hospital Grade Rental:</i></p> <ul style="list-style-type: none"> <li>• E0604</li> </ul> <p><i>Personal Use Electric:</i></p> <ul style="list-style-type: none"> <li>• E0603</li> </ul> <p><b>Breast Pump Supplies:</b></p> <ul style="list-style-type: none"> <li>• A4281, A4282, A4283, A4284, A4285, A4286</li> </ul> <p><b>Diagnosis Code(s):</b></p> <ul style="list-style-type: none"> <li>• <u>ICD-9</u>: V24.1</li> <li>• <u>ICD-10</u>: Z39.1</li> </ul>	<p><b>Support and Counseling:</b></p> <ul style="list-style-type: none"> <li>• The Diagnosis Code listed in this row is required for 99241 – 99245, 99341 – 99345, and 99347 – 99350</li> <li>• The Diagnosis Code listed in this row is not required for S9443</li> </ul> <p><b>Breast Pump Equipment &amp; Supplies:</b></p> <ul style="list-style-type: none"> <li>• Code E0604 is allowed when the "RR" rental modifier is attached.</li> <li>• The Diagnosis Code listed in this row is required for E0603, E0604 and A4281 – A4286.</li> </ul>

# United Healthcare

This policy is overlaid with the following policy that prevents lactation specialists from being paid for a variety of E & M and counseling codes.

UnitedHealthcare will not reimburse E/M services (CPT codes 99201-99499) when reported by nonphysician health care professionals reporting under their own individual or group tax identification number (TIN) assigned to one of the nonphysician health care professional specialties noted below. For purposes of this policy, the following nonphysician specialties are considered nonphysician health care professionals:

- Addiction Medicine Specialist
- Athletic Trainer
- Audiologist
- Clinical Psychologist
- Clinical Social Worker
- Home Health Specialties
- Homeopathy
- Lactation Specialist
- Neuropsychologist
- Pastoral Counselor
- Psychiatric Nurse Specialist
- Psychologist Social Worker
- Registered Dietitian
- Registered Nurse
- Surgical Assistant

There are a wide variety of CPT and Healthcare Common Procedure Coding System (HCPCS) codes that specifically and accurately identify and describe the services and procedures performed by nonphysician health care professionals.

“Lactation counseling services will be covered under code S9443 for non-physician lactation consultants. A physician who provides lactation counseling services can bill under the appropriate office visit evaluation and management (E&M) code. The service includes a face-to-face visit of no less than 30 minutes that involves the following:

- A comprehensive feeding assessment related to lactation
- Interventions including positional techniques, proper latching, and counseling
- Community support information
- Evaluation of interventional outcomes This service is only covered if it is a one-on-one session. Group sessions are not covered.

But it pays only \$9.91!

Medical lactation services shall be performed by either:

- Physicians, certified nurse midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs) who have training and experience providing medical lactation services
- International Board Certified Lactation Consultants (IBCLCs) who are employed by the physician or physician group

[https://www.kmap-state-ks.us/Documents/Content/Bulletins/18189%20-%20General%20-%20Lactation\\_Counsel.pdf](https://www.kmap-state-ks.us/Documents/Content/Bulletins/18189%20-%20General%20-%20Lactation_Counsel.pdf)

Breast Pumps are a KanCare Medicaid covered benefit. A member doesn't have to be part of Healthy First Steps ([uhcbabyblocks.com](http://uhcbabyblocks.com)) to get a Breast Pump.

KMAP for Kansas DME:

E0602 - manual breast pump

E0603 - (breast pump, electric These are covered but not more than one total per year

Replacement parts are limited to no more than two of each per year:

A4281- Replacement breast pump tube; A4282 - Adapter for breast pump, replacement

A4283 - Cap for breast pump bottle, replacement

A4285 - Polycarbonate bottle for use with breast pump, replacement

A4286 - Locking ring for breast pump, replacement

Non-covered breast pumps and accessories:

E0604 - Hospital grade breast pump is not covered

A4284 - Breast shield and splash protector for use with breast pump, replacement

<http://ksbreastfeeding.org/wp-content/uploads/2020/03/KanCare-BREAST-PUMP-info.pdf>



# How To Code Effectively

## **MOST EFFECTIVE: Lactation Consultant + Physician (or Mid-Level)**

### **JOINT VISIT**

- ◆ This is a physician visit which is supported and facilitated by the initial work of the allied health professional.
- ◆ The latter begins the visit, records the chief complaint, documents the history, establishes key physical findings, observes and documents the breastfeeding encounter, and counsels the patient about lactation issues related to the problem.
- ◆ The physician can join the allied health provider, infant, and mother partway through the encounter and then:
  - ◆ 1. Review the history
  - ◆ 2. Examine the infant to confirm and/or add to the physical
  - ◆ 3. Document in the chart the physician's physical findings, diagnoses and plans
  - ◆ 4. Write any necessary prescriptions With the help of the allied health provider, physician time spent on history taking, counseling, and education will be minimized.

# How To Code Effectively

## Lactation Consultant ONLY

### HEALTH BEHAVIOR ASSESSMENT AND INTERVENTION

After a breastfeeding (or any other health) problem has been established by the physician, a qualified non-physician health care professional may see the patient to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems.

1. These visits require a medical condition (eg, feeding problem or slow weight gain) previously diagnosed by the physician or other qualified health care professional
2. These health and behavior visits may not be reported on the same day as any other E/M service by the same provider
3. These visits are not for generalized preventive counseling or risk factor reduction
4. These codes are reported based on the allied health professional's time (they are not for use by physicians or other billable licensed health care provider).

If covered by the insurer, these codes are a good way to pay for your office lactation consultant who is not otherwise licensed or credentialed for billing.

# How To Code Effectively

## Health behavior assessment and intervention codes

- **96156** Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
- **96158** Health behavior intervention, individual, face-toface; initial 30 minutes; **+96159** Health each additional 15 minutes
- **96164** Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes; **+96165** each additional 15 minutes
- **96167**, Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes, **+96168** each additional 15 minutes
- **96170** Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes; **+96171** each additional 15 minutes

*\*Codes 96150-96154 were deleted in CPT for 2020 and replaced with 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171*

# A Note About Health Behavior Codes

**Codes 96150-96154 were deleted for 2020 and replaced with 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171**

- These codes have much higher Relative Value Units (RVUs) than the old codes (96150-96154)

## RVU Examples:

- **96156:** Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making) = 3.115 RVUs, equal to \$112.41 on the National Medicare Fee Schedule 2020
- **96158:** Health behavior intervention, individual, face-to-face; initial 30 minute = 2.109 RVUs, equal to \$76.10 on the National Medicare Fee Schedule 2020

# Billing Mother & Child

## When Both The Baby and The Mother Are Treated

You can bill for both patients **if** the physician or other billable licensed health care provider is taking the mother's history, examining her breasts and nipples, observing a feeding, and making a diagnosis and treatment plan, while the clinician is treating a second patient.

This would change the visit into two separate and identifiable visits with two different patients—two patients, two visits, two records, two bills, and two co-pays.

Remember under the ACA provisions, in order to not incur cost sharing, these services may need to be submitted under the mother and not the infant.

- Depending on the mother's insurance, you may need to get a request from her primary care health care provider.
- Can be billed either as a new patient (99201-99205) or, if you have a request and will make a written report back to the requesting source, as a consult (99241-99245)

# A Note About Telemedicine

## Most Payers are Covering Services Delivered via Telemed During Covid19

**BUT ALL THE SAME POLICY RULES STILL APPLY**

Physician/Provider Claims for professional services should be submitted using the appropriate service code and the modifier 95 or GQ.

Check with each Payer to determine which services will be covered, by whom and with what modifier and place of service codes.

# Who Should Use What Code?

## Non-licensed and non-participating IBCLCs / CLCs:

- ◆ Keep it to counseling and education
  - S9443 (Classes, per session)
  - 99401-99404 (Individual counseling, per 15 minute increment)
  - 99411 and 99412 (Group Counseling, 30 and 60 minutes)
  - 98960-98962 (Education for patient self-management)
  - 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 (Behavioral health & intervention codes)

## Licensed and/or Participating Providers:

- ◆ Can utilize more specific E & M codes
  - 99201-99203 (New, office) / 99211-99214 (Established, office)
  - 99341-99345 (New, Home visit)
  - 99347-99350 (Established, Home visit)
  - 99241-99245 (Referred Consultations)
  - 99401-99404 (Individual counseling, per 15 minute increment)

# Non-Licensed Independent IBCLC / CLC

If insurers state that they will not pay for E & M codes due to your lack of license, you can bill “non physician” behavioral assessment codes.

Difference in payment rates:

- **96158** (Health behavior assessment, 30 mins) has RVUs of **2.109** = **\$76.10\*** (office setting)
- **99401** (15 minutes counseling) has RVUs of **1.139** = **\$48.31\*** (office setting)
- **99211** (E & M ‘nurse’ visit) has RVUs of **0.771** = **\$27.81\*** (office setting)

\* CMS National Fee Schedule 2020



# Use Caution When Coding & Billing

## Proceed with caution when coding and billing!

Just because an insurer pays for the claim, it doesn't mean that you are doing it 'right'.

- Some IBCLCs are billing under physicians without following key insurance rules. Yes, you'll get paid because the insurer is receiving a claim from the **Physician**. But the insurer may exclude the non-licensed professional from billing that way (see UHC's policy)
- Always find out exactly what an Insurer covers, who they will pay, and how they will pay

# A Note About 99401-99404

**99401 - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes**

**99402 = 30 minutes / 99403 = 45 minutes / 99404 = 60 minutes**

- Most commercial insurers, and the KS Medicaid plan, recognize these codes.
- They pay relatively well as they have equivalent RVUs to office visits.
- **But again, make sure that you understand each Payers' policy on these codes BEFORE you use them. . .**

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