

# Supporting Breastfeeding and Lactation: The Primary Care Pediatrician's Guide to Getting Paid

Breastfeeding support can often be quite time-intensive initially but pays off in a healthier patient population. It is in your insurers' best interests that you provide these services, and be reimbursed appropriately.

This pamphlet is a guide to help pediatric practitioners get paid appropriately for their time as they incorporate more breastfeeding support into their practices.

Billing for problems with breastfeeding and lactation is just like billing for any other pediatric problem.

Pediatricians and other billable licensed practitioners (nurse practitioners\* and physician assistants\*) may:

- Use standard CPT codes, e.g., 99212–99215
- Use standard ICD-9-CM codes, e.g., 779.31 or 783.3
- Code based on time, if greater than 50% of time is spent in counseling, education, or coordination of care
- Use modifier 25 appended to a separately reported office or other outpatient service to bill for extended time spent on feeding problems at a well baby visit.
- Bill for care provided for the mother, often as a new patient, in addition to billing for the baby, if history, exam, diagnosis and treatment are done for her.

The practice can also, under specific circumstances, charge for services provided by nurses and such allied health professionals as lactation consultants, health educators, and nutritionists, using a variety of codes.

### This pamphlet discusses:

1. Commonly used ICD-9-CM codes
2. Options for billing the three-to-five day visit
3. Billing for extra time spent at well baby visits
4. Use of time-based coding
5. Billing for consults
6. Billing for care provided for the mother
7. Billing for allied health professional services

\*Unless restricted by their state or payors' scope of practice limitations. This pamphlet does NOT discuss the detailed, important and specific guidelines affecting decisions about billing for nurse practitioners and physician assistants, i.e., whether credentialed and billed under their own names vs. billing for their services "incident to" physician care and thus billed under the physician's name. That topic is beyond the scope of this pamphlet. However, all physicians employing such allied health care providers need to be aware of, and understand, the applicable billing rules, and apply them carefully—whether billing for feeding problems, or for any other medical services in the pediatric office.

## Commonly used ICD-9-CM codes

### Baby

#### **Feeding problems**

Feeding problems/ slow feeding, newborn	779.31
Bilious vomiting in newborn	779.32
Other vomiting in newborn	779.33
Feeding problem, infant (> 28 days)	783.3
Vomiting, infant (>28 days)	787.03

#### **Jaundice**

Breastmilk jaundice	774.39
Neonatal jaundice, unspecified	774.6
Preterm jaundice	774.2

#### **Weight and hydration**

Dehydration, neonatal	775.5
Failure to thrive, newborn	779.34
Weight loss	783.21
Underweight	783.22
Slow weight gain, FTT, infant (>28 days)	783.41
Abnormal weight gain	783.1
<i>As well as all the diagnoses associated with size and maturity.</i>	

#### **Infant distress**

Fussy infant/baby	780.91
Excessive crying, infant	780.92
Infantile colic or intestinal distress	789.7

#### **GI issues**

Abnormal stools	787.7
Diarrhea	787.91
Change in bowel habits	787.99

#### **Mouth**

Ankyloglossia	750.0
High arched palate	750.26

### Other

Other specified follow-up exam	V67.59
<i>(When the original reason for visit has resolved)</i>	

### Mother

#### **Breast & Nipple issues**

Abscess, breast / Mastitis, infective	675.14
Blocked milk duct / Mastitis, interstitial	675.24
Breast engorgement, ductal	676.24
Burning pains, hyperesthesia	782.0
Ectopic or axillary breast tissue	757.6
Galactocele	676.84
Other specified nipple/breast anomaly	757.6
Other specified nipple/breast infection	675.84
Nipple infection	675.04
Nipple, cracks or fissures	676.14
Nipple, sore	676.34
Retracted nipple, postpartum	676.04
Impetigo (staph), nipple	684
Candidiasis, nipple or breast	112.89

#### **Constitutional**

Disrupted sleep cycle	780.55
Fatigue	780.79

#### **Lactation**

Agalactia, failure to lactate	676.44
Lactation, delayed	676.84
Lactation, suppressed	676.54
Other specified disorders of lactation	676.84
Supervision of lactation	V24.1

### Other

Other specified follow-up exam	V67.59
<i>(When the original reason for visit has resolved)</i>	

## The three- to five-day visit

The AAP recommends <sup>1,2,3</sup> this visit

- to assess jaundice in ALL infants, regardless of feeding method.
- to address other early feeding issues

For breastfeeding infants, the purpose of this visit is

- to assess weight, hydration and jaundice and
- to address the ability of the infant to:
  1. Maintain hydration AND
  2. Sustain growth and activity AND
  3. Increase and maintain maternal production.

This assessment usually includes:

1. History: Infant feeding, sleep and activity patterns, urine and stool output; maternal lactogenesis, comfort and confidence
2. Exam: Weight, and exam for dehydration, sleepiness and level of jaundice
3. If indicated, observation of a feeding, including weights before and after feeding
4. Testing, interventions, and counseling if indicated

The visit may be billed as either

- a first routine well visit OR
- a follow-up visit, for a problem noted earlier

### Billing as a well visit

If the infant's previous record does not document a feeding problem, and no other health problem has been identified, then this first office visit *should be coded and billed as an established patient well-child visit.*

- CPT code 99391
- ICD-9-CM V20.32 ( and any other indicated diagnosis codes, e.g., for jaundice or feeding problem)

In any well visit, the clinician is expected to spend time addressing routine feeding issues. When unusual time beyond the usual is required, there are two ways of billing for this extra time.

### When extra time is required:

If, a feeding problem exists which requires *more* than an ordinary amount of time to address, the physician may, depending on the circumstances, choose one or both of the following options, as clinically appropriate:

- Prefer to spend extra time at this visit to address the problem immediately. This may then be billed separately using the 99212-99215 codes appended with the modifier 25, following the guidelines described on the next page
- Schedule a follow-up visit, for example, within a few days, or at one to two weeks of age. That follow-up visit would then be billable using the office follow-up codes (99211-99215) related to that feeding problem diagnosis.

### Coding and billing as a follow-up visit

**For this to be billed as a follow-up visit, the reason for follow-up must be clearly established on the preceding health or hospital record.**

- The earlier chart must document the unresolved problem that requires a follow-up visit.
- An appropriate diagnosis code, e.g., "newborn feeding problem" (779.31), or "jaundice" (774.6) must be included with the hospital or birth center's discharge diagnoses, to establish the reason for the follow-up visit.
- Alternatively, telephone chart notes document that, since discharge, a new problem exists.

Examples of early problems requiring follow-up include, but are not limited to:

- Jaundice
- Infrequent and/or dark stools
- Ability to transfer milk not established
- Infrequent breastfeeding
- Weight loss exceeds 7%
- Breastfed infant being fed formula

**Options for coding and billing** as a follow-up visit:

#### **1. Schedule routinely with physician or billable licensed health care provider (e.g., NP or PA):**

Use office follow-up codes 99212–99215 and appropriate ICD-9-CM codes:

- If the feeding problem persists, use an ICD-9-CM such as 779.31, 774.6, 783.21, etc.
- If, however, the feeding problem has resolved, use instead ICD-9-CM code V67.59, just as you would for a follow-up resolved otitis media.

#### **2. Nurse visit with possible triage to physician or other billable licensed health care provider**

This is a weight check and quick screen for feeding, sleep, and stool patterns. It is only billable to the nurse as a 99211 if it is NOT triaged to the doctor. Triage based on adequacy of feeding:

- a. *If this visit demonstrates that good feeding has been established*, the physician does not need to see the patient to bill for a limited nurse's visit with CPT code 99211 and ICD-9-CM code V67.59.
- b. *If nurse's weight check visit reveals persistent problems*, you do NOT bill for the nurse visit but instead triage back to pediatrician, or other billable health care practitioner (NP or PA) immediately for a problem visit, billable as a follow-up visit (99212–99215)

## **Billing for extra time spent on feeding problems at any well baby visit**

If, at a well visit, a significant, separately identifiable, diagnosable feeding *problem* necessitates extra time beyond routine well visit feeding counseling, then the 99212-99215 codes appended with the modifier 25 may be reported in addition to the preventive medicine service code.

*A separate note is optimally written, on a separate page or on the same page with a line separating the two notes: the well visit note and the problem based note.*

*Furthermore, the problem-based note will require that all required key components of appropriate time-based billing is documented for the code selected.*

Both visits are then reported, appending the modifier 25 to the problem-based visit code. For example, using an established patient 8 to 28 days old, you would report:

**99391                      V20.32**  
**99213-25                779.31**

**Note:** Some insurers do not recognize modifier 25.

## **Billing for any clinician's visit based on time**

Because breastfeeding visits are dominated by counseling and education, they can be time-intensive.

The CPT guidelines allow for a visit to be billed based on time, rather than by meeting the E/M requirements for elements of history, physical, and decision-making, *if*:

1. More than 50% of the practitioner's face-to-face time with the patient has been spent on counseling (patient education) or coordination of care
2. You must document *on the chart*.
  - a. Your total face-to-face time with the patient and/or the patient's family.
  - b. Time spent in counseling or coordination of care (and this must be > 50% of total)
  - c. A brief description of what was discussed (should be one or more: diagnosis or impressions; prognosis; risks/benefits of management options; instructions for management and follow-up; compliance issues; risk factor reduction; patient and family education); a checklist on your encounter form will make this easier for all time-based visits, not just those about breastfeeding issues

You can bill for time for most routine E/M codes, e.g., 99212–99215, when counseling, education, or coordination of care dominate a visit otherwise not meeting customary guidelines for history, physical, and medical decision-making. (but it should be noted that time-based billing cannot be used with the preventive medicine service codes, since their CPT code descriptors do not contain "typical times")

### **The CPT E/M guidelines for billing based on time:**

<i>New</i>		<i>Established</i>		<i>Outpatient</i>	
<i>Patient</i>	<i>Time</i>	<i>Patient</i>	<i>Time</i>	<i>Consult</i>	<i>Time</i>
99202	20	99212	10	99241	15
99203	30	99213	15	99242	30
99204	45	99214	25	99243	40
99205	60	99215	40	99244	60
				99245	80

[For example, if you spent 30 minutes face to face with an established baby and mother, of which greater than 15 minutes were spent counseling about feeding issues, you could bill with CPT code 99214, ignoring the usual history, exam, and medical decision-making requirements for a 99214. Your chart documentation must include the three elements described above: total physician face-to-face time, total time spent counseling, and a description of that counseling.]

## **Consultations**

The physician or individually credentialed nurse practitioner or physician's assistant\* may also bill the initial feeding evaluation as a requested consultation if the following guidelines are met:

**A requested consultation (99241–99245)** requires the "3 Rs," *documentation on chart of*:

1. **Request** (whether verbal or written) from another physician (even within the practice) "or other appropriate source" (can be a lactation consultant or even a La Leche League leader) is documented and the original request is to gather your advice or opinion. This cannot be a transfer of care.

2. **Render** the service requested
3. **Report** back to requesting source (Note: must be a written report.)

Billing for codes 99241-99245 may be based either on key components or time.

**Follow-up visits** will be billed as established patients (99212–99215).

\* An allied health care provider cannot bill a consult under the "incident to" billing options. Only a nurse practitioner or physician's assistant who has been credentialed individually by an insurance company may bill for either of these types of consults under that provider's own name. Note: This is subject to individual state and payor limitations.

## Billing for the infant's mother

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 for her, the clinician is treating a second patient. This may change the visit with the baby into two separate and identifiable visits with two different patients—two patients, two visits, two records, two bills, and two co-pays.

- 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)

## Billing for services by allied health providers who are neither nurse practitioners nor physician's assistants

Services provided by an allied health professional who is *not* a billable and credentialed nurse practitioner or physician's assistant, (e.g., a nurse, health educator, or lactation consultant) can be billed two ways.

- A. The allied health professional's time can be used to make the physician's time more productive.
- B. The Health Behavior Assessment and Intervention codes allow the allied health professional to see the patient alone and bill for the allied health professional's face-to-face time.

### A. Joint visit physician and allied health professional: (99212–99215)

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, baby, 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.

History, physical, and medical decision-making guidelines will be used to decide the level of the visit code (99212–99215). Time based coding cannot be used for this visit because the physician will have spent relatively little time face-to-face with the family. Time based coding is based specifically on the physician's time, NOT the allied health professional's time.

### B. Health and Behavior Assessment and Intervention codes

After a breastfeeding (or any other health) problem has been established *by the physician*, an allied health provider may see the patient to focus on “the biopsychosocial factors, important physical health problems, and treatments” (the AMA's CPT 2006 manual, page 399). The following conditions apply:

1. *These require a medical condition* (e.g., feeding problem or low weight gain) **previously diagnosed by the physician at an earlier date.**
2. These health and behavior visits may not be reported on the same day as any other E/M service.
3. These visits are not for generalized preventive counseling or risk factor reduction.
4. These are billable in 15-minute time increments, based on the allied health professional's time (they are not for use by physicians or other billable licensed health care provider). If honored by the insurer, these codes are well reimbursed and are a good way to pay for your office lactation consultant who is not otherwise licensed or credentialed for billing.

### Codes

- **96150** Initial health and behavior assessment (clinical interview, behavioral observations, health questionnaires, etc.):  
*Each 15 minutes face-to-face time*
- **96151** Reassessment
- **96152** Health and behavior intervention, individual  
*Each 15 minutes face-to-face time*
- **96153** Health and behavior intervention, group (two or more patients)  
**Note:** you will need a group of five or six to be reimbursed for the allied health professional's time equivalently to the individual or family sessions.  
*Each 15 minutes face-to-face time*
- **96154** Health and behavior intervention, family, with patient present  
*Each 15 minutes face-to-face time*
- **96155** Health and behavior intervention, family, without patient present  
*Each 15 minutes face-to-face time*

## Billing for phone calls and online communications

Certain non-face-to-face services codes have been updated for 2008. The updated E/M codes for telephone and online medical discussions permit billing for both physician services and services provided by “qualified non-physician health care professional(s)”.

Billing for these services is limited to the following circumstances:

- The telephone or online communication is with an established patient, or an established patient’s parent or guardian. NOT for NEW patients.
- *The online codes (but not the telephone codes) additionally may be used for communications with the patient’s health care provider.*
- The telephone or online service does *NOT originate* from a related E/M service or procedure for that patient within the previous 7 days
- The telephone E/M codes may NOT be used if the call leads to a face-to-face E/M service or procedure within the next 24 hours, or the soonest available appointment. (The online E/M codes do not carry this restriction.)

*Note: Not all insurers reimburse for these codes.*

### Telephone Calls

Provided the criteria above are met, telephone calls may be billed using the following codes:

Medical Discussion in minutes	Physician Calls	Non-physician Provider Calls
5-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968

<sup>1</sup> American Academy of Pediatrics, Subcommittee on Hyperbilirubinemia. Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics*. 2004;114:297-316

<sup>2</sup> American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2000;105:645

<sup>3</sup> American Academy of Pediatrics, Committee on Fetus and Newborn. Hospital stay for healthy term newborns. *Pediatrics*. 1995;96:788-790

### Online Medical Evaluations

E/M services

- provided to an established patient, or to that patient’s parent, guardian or health care provider
- using the internet or similar electronic communications network
- not originating from a related E/M service in the previous 7 days may be billed, regardless of length, using codes
- 99444 for services provided by a physician
- 98969 for services provided by a qualified non-physician health care professional.

### Billing for interdisciplinary team conferences

The codes for billing for participation in interdisciplinary medical team conferences attended by other health professionals have been updated for 2008.

To bill for participation in team meetings when the patient or family is present

- Physicians continue to use regular E/M codes, e.g. 99214 or 99215, using time as the controlling factor, based on face-to-face time spent on “counseling and coordination of care.”
- To bill for participation by non-physician qualified health care professionals, use 99366 for meetings of 30 minutes or more

To bill for participation in team meetings of 30 minutes or more when the patient or family is NOT present:

- 99367 participation by physician
  - 99368 participation by non-physician qualified health care professional
- To bill for codes 99366, 99367, 99368 there must be a minimum of 3 qualified health care professionals in attendance