Reimbursement Questions and Answers for IBCLCs

Judith L. Gutowski, BA, IBCLC, RLC
Chair, USLCA Licensure and Reimbursement Committee
June 2012

The USLCA often receives inquiries about insurance and Medicaid billing and reimbursement for IBCLC services. The answers to these types of questions require consideration of many factors so there is no single solution that can be provided. In general, coding strategies and reimbursement will vary with the type of facility or the location one works in, such as a hospital, clinic, physician or private practice. Reimbursement can also depend on the credentials of the person providing the service and whether there could be a licensed provider available to share the visit.

Regardless of the complexities, it is very important for IBCLC to be integrated into the health care system, despite its imperfections, because we have so much to offer. Our professional viability and forward momentum necessitate this integration. In the long run, our financial wellbeing as a profession will benefit. There will be places where insurance coverage will be a huge benefit, and other places where it might not be as beneficial. IBCLCs will always have the opportunity to participate as a covered provider or not. It is a voluntary system.

Here is a list of common questions and answers that may be useful to IBCLCs.

Q: What is going on nationally and in my state regarding ability to get insurance reimbursement for lactation consultations?

A: IBCLCs are currently not licensed providers in any state; however, the USLCA is coordinating efforts throughout the country to establish licensure. Some IBCLCs can bill commensurate with their background within health care practices and these services will be covered by insurance at their usual rates. For example as a physician, registered nurse, nurse practitioner, physician assistant, licensed nutritionist, therapist or other licensed provider type. Alternatively, when working *with* licensed providers IBCLCs may be able to be "incident to" providers under section 2050.1 of the Medicare Claims Processing Manual "Incident to Physician's Professional services" available here. Unfortunately, IBCLCs without a license and working independently have the least options for reimbursement. They can provide their services to clients on a "self-pay" basis and certainly their clients can ask the insurer to cover services, but there is not standard acceptable coverage.

Q: How are lactation services provided by an IBCLC billed for in a physician practice?

A: For billing within a pediatric practice please refer to the AAP Coding document, "Supporting Breastfeeding and Lactation: The Primary Care Pediatrician's Guide to Getting Paid" http://www2.aap.org/breastfeeding/files/pdf/coding.pdf

This gives a number of options for billing for lactation services. The billing specialists within the practice should be familiar with these codes and procedures and can help to determine what is best in your situation. However, there is no mechanism for pre-natal billing because you don't have a pediatric patient yet.

Working in an obstetric practice is different. For prenatal visits you are typically going to be educating (which means you are not providing individual care such as the risk assessment described above) therefore, might do better with a class billing as S9443. You would first want to have the billing folks run those codes with the primary insurers in your area to see if they pay for that code. For individual pre-natal visits with an obstetrician your visit might instead be a lactation "risk assessment" including review of relevant maternal history, assessment of breasts and nipples and provision of anticipatory guidance regarding lactation. This might be able to be billed as a visit "shared" with the physician.

Generally, the shared visit option seems to work best. If the doctors you are working for are on-site where you see mothers. Your appointments would be part of well or sick visits. The patient would see the doctor and see you.

Q: Can I bill just an RN?

A: Billing for the nurse independently is usually coded as "99211" and generally meant to be used for brief visits such as a weight check, allergy shot, or immunization. These are usually < 10 minutes in length. Therefore, the codes are reimbursed at low rates (< $20) that would not cover the cost of providing an hour or more lactation visit. Your state may have other guidelines; this will vary with state licensure legislation and state Medicaid regulations.

Q: Can I bill as an IBCLC and is there a code book that you would recommend?

A: The AAP Coding document cited above, gives CPT codes used by physicians as well the diagnosis codes for these services. However, based on review of the CPT guidance, none of these codes appears to specifically describe lactation consultant services. It is unlikely that the E/M codes (99212, 99213, 99214, 99215, 99243, 99244, 99245, 99401, 99402, 99403, 99404, 99429) can be used independently by lactation consultants, as the descriptions of these codes are very broad, and lactation consultant services are not defined by state law, meaning that payers, such as Medicaid, would be concerned about what service is actually being provided.

If none of the existing codes appropriately describe the service, lactation consultant services could be reported with, the miscellaneous code S9445 (patient education, not otherwise classified, non-physician provider, individual, per session), or unlisted code 99429 (Unlisted preventive medicine service). However, this would require that the IBCLC educate their contracting insurer about appropriate billing and reimbursement for services with these codes. Alternatively, lactation consultants could bill for services with S9443, however, rates for S9443

are generally very low (i.e., $20 per service) if they are reimbursed as a covered service by certain providers.

Q: IBCLCs have been invited to become in-network Providers by an insurance group. How do we do this?

A: For private insurers, IBCLCs may be able to be credentialed by a private insurer. The insurer will determine what qualifications must be met to serve as a lactation provider. Ideally, this would be permitted based on the IBCLC certification. Each IBCLC must negotiate a contract based on meeting the qualifications. This contract would also determine the amount of your reimbursement. The insurer can choose to assign certain codes to cover your services. This would have to be arranged individually with each provider. Again, this would require that the IBCLC educate their contracting insurer about appropriate billing for "lactation evaluation and management" visits and acceptable reimbursement for these services.

Theoretically, this improves your marketability. What the IBCLC must decide is whether the amount that the insurer asks you to accept is financially feasible. If it is not, bargain to see if there is any flexibility with them, and if not, the IBCLC either accepts at a loss on the hopes that you will increase the client base, or decline to be an in-network provider.
What is different for IBCLCs is that insurance companies may not be familiar with our services or what we expect in payment, so they may be offering a low rate purposefully or not.
Here are some of the things an IBCLC might ask:

- Will they cover you for the cost of the mother and the baby in the same visit? In that way, your total reimbursement for a visit is acceptable.
- What rates are other private clinicians receiving who might have lengthy visits such as those for lactation, i.e. Physical therapists? Occupational therapists? Speech Pathologists?
- Is there a limit on the number of visits they will cover?
- Are they limiting the type of care you can provide in any way?
- What lactation codes are they accepting?
- Is there a limit on the age of the baby they will cover? Or the postpartum period for the mother?
- How much time do they think you will spend on the visit?
- Do they care where you see the patient, or will they only accept care given in a medical facility?
- Can you charge extra for mileage for a home visit?

Q: Can an IBCLC be reimbursed by Medicaid?

A: For Medicaid reimbursement, all providers must hold a license according to federal regulations; however those holding licenses other than physicians such as RN's, dieticians, midwives and others are not independently reimbursable in all states. This would have to be researched within your Medicaid own state regulations. It is also important to consider what

billing codes may be used for various types of providers and what the reimbursement rate is. It may not financially feasible for lactation visits to be covered at the usual rates for brief visits since lactation visits involve two patients are generally much more time intensive than most provider visits. Be aware that with Medicaid, lactation counseling will usually fall under preventive services that must be provided with no cost-sharing to the client so if reimbursement is low you cannot bill the client for any balance.
Medicaid published an Issue Brief on provision of lactation services. It is available at:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf

Q: Is the IBCLC required to accept whatever the insurance company decides to pay as payment in full for services?

A: This is the collaborative process all providers and insurance companies share. The insurer offers you a payment for being an 'in-network' provider. They want to guarantee that their clients will not be charged extra. In return, they take away the worry of compensation from you. You don't have to involve your client, you communicate with the insurance company.

When an IBCLC accepts such a contract with an insurer for reimbursement, they must negotiate these rates. If the insurer offers a rate that is not acceptable you do not have to accept a contract with that insurer. The rates or reimbursement and eligibility co-pays or co-insurance may be different based on certain variables such as:

- Initial versus follow-up visits
- Home, in-patient or out-patient settings
- Preventive (well) visits versus sick visits

Q: If the insurer / Medicaid "patient benefit" requires no deductible, no co pay, no coinsurance, no out of pocket anything for the client / patient, can the IBCLC ask the client / patient to pay the balance?

A: If the services are not "coded" as preventive care, then a co-payment may be allowed. Under the current laws of the Affordable Care Act (ACA), preventive services are required to have no cost-sharing to the patient so the IBCLC cannot ask for any further payments from the client. This may change if the ACA is repealed.

Q: What are the billing codes for lactation services?

A: The Healthcare Common Procedure Coding System (HCPCS) coding system utilized by the Medicaid program is comprised of two parts.
Level I is the Current Procedural Terminology® (CPT),[1] maintained by the American Medical Association (AMA), and Level II is the HCPCS national code set, maintained by the Centers for Medicare & Medicaid Services (CMS).

The CPT and HCPCS codes that may be relevant to lactation consultant services are included in the following table. However, none of these codes seems to adequately account for the description, time involved and nature of a lactation visit.
In light of these limitations with respect to the existing CPT codes, USLCA has applied for a new HCPCS code to describe lactation consultant services, "lactation evaluation and management". This code would be "per 15 minutes" so the units would be added to equal the time it takes to do the visit, typically 1-2 hours. The next step after obtaining a code is to work for appropriate reimbursement for that time spent by an IBCLC for the visit. We are awaiting response to our application and will inform IBCLCs if / when such a relevant code becomes available.

CPT Code	Description
S9443	Lactation Classes, Non-Physician Provider, Per Session
96150	Health and Behavior Assessment (eg, Health-Focused Clinical Interview, Behavioral Observations, Psychophysiological Monitoring, Health-Oriented Questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151	Health and Behavior Assessment (eg, Health-Focused Clinical Interview, Behavioral Observations, Psychophysiological Monitoring, Health-Oriented Questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96152	Health and Behavior Intervention, Each 15 Minutes, face-to-face; Individual
96153	Health and Behavior Intervention, Each 15 Minutes, face-to-face; Group
96154	Health and Behavior Intervention, Each 15 Minutes, face-to-face; Family (With the Patient Present)
96155	Health and Behavior Intervention, Each 15 Minutes, face-to-face; Family (Without the Patient Present)
97802	Medical Nutrition Therapy; Initial Assessment and Intervention, Individual, Face-to-Face with the Patient, each 15 minutes
97803	Medical Nutrition Therapy; Re-Assessment and Intervention, Individual, Face-to-Face with the Patient, each 15 minutes
97804	Medical Nutrition Therapy; Group (2 or more individual(s)), each 30 minutes
98960	Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/Family) Each 30 Minutes; Individual Patient
98961	Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/Family) Each 30 Minutes; 2-4 Patients
98962	Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/Family) Each 30 Minutes; 5-8 Patients
99212	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires At Least 2 Of These 3 Key Components: A Problem Focused History; A Problem Focused Examination; Straightforward Medical Decision Making. Counseling And/Or Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s)

	And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Self Limited Or Minor. Physicians Typically Spend 10 Minutes Face-To-Face With The Patient And/Or Family.
99213	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires At Least 2 Of These 3 Key Components: An Expanded Problem Focused History; An Expanded Problem Focused Examination; Medical Decision Making Of Low Complexity. Counseling And Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Of Low To Moderate Severity. Physicians Typically Spend 15 Minutes Face-To-Face With The Patient And/Or Family.
99214	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires At Least 2 Of These 3 Key Components: A Detailed History; A Detailed Examination; Medical Decision Making Of Moderate Complexity. Counseling And/Or Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 25 Minutes Face-To-Face With The Patient And/Or Family.
99215	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires At Least 2 Of These 3 Key Components: A Comprehensive History; A Comprehensive Examination; Medical Decision Making Of High Complexity. Counseling And/Or Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 40 Minutes Face-To-Face With The Patient And/Or Family.
99243	Office Consultation For A New Or Established Patient, Which Requires These 3 Key Components: A Detailed History; A Detailed Examination; And Medical Decision Making Of Low Complexity. Counseling And/Or Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Of Moderate Severity. Physicians Typically Spend 40 Minutes Face-To-Face With The Patient And/Or Family.
99244	Office Consultation For A New Or Established Patient, Which Requires These 3 Key Components: A Comprehensive History; A Comprehensive Examination; And Medical Decision Making Of Moderate Complexity. Counseling And/Or Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 60 Minutes Face-To-Face With The Patient And/Or Family.
99245	Office Consultation For A New Or Established Patient, Which Requires These 3 Key Components: A Comprehensive History; A Comprehensive Examination; And

	Medical Decision Making Of High Complexity. Counseling And/Or Coordination Of Care With Other Providers Or Agencies Are Provided Consistent With The Nature Of The Problem(s) And The Patients And/Or Familys Needs. Usually, The Presenting Problem(s) Are Of Moderate To High Severity. Physicians Typically Spend 80 Minutes Face-To-Face With The Patient And/Or Family.
99401	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99429	Unlisted Preventive Medicine Service
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

Q: Can I order the Reimbursement Toolkit from USLCA?

A: The Reimbursement Toolkit is currently unavailable. We will be revising this in the near future. Pat Lindsay offers a tool kit on her website available at: http://patlc.com/LVR/