Affordable Care Act
The Affordable Care Act (ACA) has two major provisions that affect breastfeeding: (1) coverage of comprehensive lactation support and counseling; (2) costs of renting or purchasing breastfeeding equipment for the duration of breastfeeding.

These provisions, however, are typically linked to maternal benefits under payer plans and, therefore, coverage may be dependent upon submitting claims under the mother’s name. If pediatric providers provide these services and expect the claims to be adjudicated with benefits covered under ACA provisions, the claim may have to be submitted under the mother’s name. Check your payers’ essential health benefits for more details. Remember that services provided out of a payer’s network can be subject to cost sharing.

Federal support for breastfeeding
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 paid appropriately.

This document is a guide to help pediatric practitioners be 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 current CPT® codes
- Use current ICD-10-CM codes
- Code based on time, if greater than 50% of time is spent in counseling or coordination of care
- Append modifier 25 to a separately reported Office Visit code (eg, 99212) to report extended time spent on feeding problems at a Preventive Medicine Service (PMS) visit
- Provide lactation counseling via telemedicine (real-time (synchronous) interactive audio and video telecommunications system) using CPT codes listed in Appendix P (append modifier 95) [please see AAP Telemedicine Coding Fact Sheet for more information]
- Report care provided for the mother, often as a new patient, in addition to reporting services provided for the infant, if history, exam, diagnosis, and treatment are provided for the mother
- A new patient is one who has not received any professional face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

Under specific circumstances, the practice can also charge for services provided by nurses and allied health professionals (eg, lactation consultants, health educators, and nutritionists), using a variety of codes.

This document discusses:
1. Options for billing the 3-5 day visit
2. Billing for extra time spent at PMS visits
3. Use of time-based coding
4. Billing for consults
5. Billing for care provided for the mother
6. Billing for allied health professional services
7. Commonly reported ICD-10-CM codes
8. Codes for breast pumps

*Unless restricted by state or payer scope of practice limitations. This document does NOT discuss the detailed, important and specific guidelines affecting decisions about billing for nurse practitioners and physician assistants (ie, 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 document. However, all physicians employing such allied health care providers need to understand the applicable billing rules and apply them carefully—whether billing for feeding problems, or for any other medical services in the pediatric office.

The Hospital Follow-Up Visit
The AAP recommends 1,2,3 this visit:
- Occur within 48-72 hours after routine discharge or if discharged before 48 hours, within 24 hours
- 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 milk production

This assessment typically 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 infant’s weight before and after feeding
4. Testing, interventions, and counseling if indicated

The visit may be billed as either:
- a new patient PMS visit OR
- an established patient Office Visit, for a problem noted earlier OR
- an allied health visit (please refer below for details)

**Billing as a new patient PMS 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 Preventive Medicine Service (PMS) visit.
- **CPT code 99391**
- **ICD-10-CM Z00.111** (and any other indicated diagnosis codes (eg, for jaundice or feeding problem))

In any PMS visit, the physician 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 that requires more than the typical amount of time, the physician may 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 below
- Schedule a follow-up visit (eg within a few days or at one to two weeks of age). The follow-up visit will be billable using codes 99211-99215, with the diagnosis linked to the feeding problem.

**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 in the health or hospital record.
- The chart must have already documented the unresolved problem that requires a follow-up visit
- An appropriate diagnosis code (eg, “newborn feeding problem” (P92.8), or “jaundice” (P59.8)) must be included in the hospital or birth center’s discharge diagnoses, to establish the reason for the follow-up visit
- Alternatively, telephone chart notes document a new problem has arisen since discharge

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%, or >75% on NEWT curve (https://www.newbornweight.org/)

**Options for coding and billing as a follow-up visit:**
1. Schedule follow-up visit with physician or billable licensed health care provider (eg, NP or PA):
   - Use codes 99212–99215 and appropriate ICD-10-CM codes:
     - If the feeding problem persists, use an ICD-10-CM such as P92.2, P92.3, P92.5, P92.8, etc.
     - If the feeding problem has resolved, use ICD-10-CM code Z09 instead, 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 with 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 and report a 99211 and ICD-10-CM code Z09
     b. If nurse’s weight check visit reveals persistent problems and you triage back to pediatrician or other billable health care practitioner (NP or PA) immediately for a problem visit, billable as 99212–99215 instead

3. Telemedicine visit
   - Telemedicine is defined as a real-time (synchronous) interactive audio and video telecommunications system. However, during public health emergencies (PHE), some payers may allow audio-only. This is a visit to follow-up on new issues or problems identified during the first in-person hospital follow-up visit. This visit should not replace the in-person hospital follow-up visit. Telemedicine visits are appended with modifier 95. [please see AAP COVID PHE Coding Resource for more information]
If a significant, separately identifiable, diagnosable feeding problem necessitates extra time beyond typical PMS visit feeding counseling, report 99212-99215 appended with the modifier 25 in addition to the PMS code.

Optimally, a separate note is written on a separate page or on the same page with a line separating the two notes: the PMS visit note and the problem-based note. 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td></td>
<td>Z00.111</td>
</tr>
<tr>
<td>99212-25</td>
<td></td>
<td>P92.5</td>
</tr>
</tbody>
</table>

**Note:** Even though CPT guidelines permit such reporting, some payers do not pay for both E/M services on the same date of service.

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

**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 use time as the key factor for most routine E/M codes (eg, 99212–99215) when counseling, education, or coordination of care dominate a visit otherwise not meeting customary guidelines for history, physical, and medical decision-making. (It should be noted that time-based billing cannot be used with the PMS codes, since their CPT code descriptors do not contain discrete “typical times”). Also note that typical times are not threshold times and you do not need to reach the time listed in a specific code in order to report it, but must be closer to that time, then the time listed in the code below.

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

<table>
<thead>
<tr>
<th>Patient Time</th>
<th>Established Patient Time</th>
<th>Outpatient Consult Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202 20</td>
<td>99212 10</td>
<td>99241 15</td>
</tr>
<tr>
<td>99203 30</td>
<td>99213 15</td>
<td>99242 30</td>
</tr>
<tr>
<td>99204 45</td>
<td>99214 25</td>
<td>99243 40</td>
</tr>
<tr>
<td>99205 60</td>
<td>99215 40</td>
<td>99244 60</td>
</tr>
</tbody>
</table>

*For example, if you spend 35 minutes face to face with an established infant and mother, of which greater than 18 minutes is spent counseling about feeding issues, you can bill with CPT code 99215, ignoring the usual history, exam, and medical decision-making requirements for a 99215. Since 35 minutes is closer to 40 minutes (99215) than 25 minutes (99214), you will report a 99215. 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 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 are billed with 99212-99215

* An allied health care provider cannot bill a consult under the “incident to” billing options. Only a nurse practitioner or physician 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 payer 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, the clinician is treating a second patient. This may change the visit with the infant 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)

Billing for services by allied health professionals

Services provided by an allied health professional who is not a billable and credentialed nurse practitioner or physician assistant, (eg, a registered nurse, health educator, or lactation consultant) can be difficult. Rules can vary by state, by scope of practice, by payer and therefore any guidance found here should be double-checked. It is important to remember that certain providers are allowed to be credentialed by payers, thus opening up more codes and services for payment. For those clinical staff who cannot be credentialed by the payers, there may be serious limits put on what they can report “incident to” the supervising provider.

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, 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.

B. **Health behavior assessment and intervention codes**

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. The focus is on the biopsychosocial factors important to physical health problems, and treatments. The following conditions apply:

1. These 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.

96156 Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158 Health behavior intervention, individual, face-to-face; initial 30 minutes
+96159 Health behavior intervention, individual, face-to-face; each additional 15 minutes

Billing for telephone calls and online communications

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 (Note: the online codes do not carry this restriction)

Note: Not all insurers pay for these codes.

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

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441-99443</td>
<td>for services provided by a physician</td>
</tr>
<tr>
<td>98966-98968</td>
<td>for services provided by a qualified health care professional</td>
</tr>
</tbody>
</table>

Online Digital E/M Services

- patient-initiated through HIPAA-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital applications, which allow digital communication with the physician or qualified health care professional provided to an established patient/caregiver
- not originating from a related E/M service in the previous 7 days may be billed, regardless of length, using codes:
  - 99421-99423 for services provided by a physician
  - 98970-98972 for services provided by a qualified health care professional

Billing for interdisciplinary team conferences

To bill for participation in team meetings when the patient or family is present
- Physicians continue to use regular E/M codes (eg, 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 99366-99368 there must be a minimum of 3 qualified health care professionals in attendance

Codes for Breast Pumps

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0602</td>
<td>Breast pump, manual, any type</td>
</tr>
<tr>
<td>E0603</td>
<td>Breast pump, electric (AC and/or DC), any type</td>
</tr>
<tr>
<td>E0604</td>
<td>Breast pump, hospital grade, electric (AC and/or DC) any type</td>
</tr>
</tbody>
</table>


Commonly Reported Diagnosis Codes

Neonate/Infant

ICD-10-CM

Feeding problems
P92.01 Bilious vomiting of newborn
P92.09 Other vomiting of newborn
P92.1 Regurgitation and rumination of newborn
P92.2 Slow feeding of newborn
P92.3 Underfeeding of newborn
P92.5 Neonatal difficulty in feeding at breast
P92.6 Failure to thrive in newborn
P92.8 Other feeding problems of newborn
P92.9 Feeding problem of newborn, unspecified
R11.10 Vomiting, unspecified (>28 days old)
R11.12 Projectile vomiting (>28 days old)
R11.14 Bilious vomiting (>28 days old)

Jaundice
P59.0 Neonatal jaundice associated with preterm delivery
P59.3 Neonatal jaundice from breast milk inhibitor
P59.8 Neonatal jaundice from other specified causes
P59.9 Neonatal jaundice, unspecified

Weight and hydration
P74.1 Dehydration of newborn
P74.21 Hypernatremia of newborn
P74.22 Hyponatremia of newborn
P74.31 Hyperkalemia of newborn
P74.32 Hypokalemia of newborn
P92.6 Failure to thrive in newborn
R62.51 Failure to thrive in child over 28 days old
R63.4 Abnormal weight loss
R63.5 Abnormal weight gain
R63.6 Underweight

Infant distress
R68.11 Excessive crying of infant (baby)
R68.12 Fussy infant (baby)
R10.83 Colic

GI issues
R19.4 Change in bowel habit
R19.5 Other fecal abnormalities
R19.7 Diarrhea, unspecified
R19.8 Other specified symptoms and signs involving the digestive system and abdomen

Mouth
Q38.1 Ankyloglossia
Q38.5 Congenital malformations of palate (high arched palate)

Other
Z09 Encounter for follow-up examination after completed treatment

Mother*

ICD-10-CM

Breast & Nipple issues
B37.89 Candidiasis, breast or nipple
L01.00 Impetigo, unspecified
O91.02 Infection of nipple associated with the puerperium
O91.03 Infection of nipple associated with lactation
O91.13 Abscess of breast associated with lactation/Mastitis purulent
O91.23 Nonpurulent mastitis associated with lactation
O92.03 Retracted nipple associated with lactation
O92.13 Cracked nipple associated with lactation
Q83.8 Other congenital malformations of breast (ectopic or axillary breast tissue)
R20.3 Hyperesthesia (burning)

Constitutional
G47.23 Circadian rhythm sleep disorder, irregular sleep wake type
G47.9 Sleep disorder, unspecified
R53.83 Fatigue

Lactation
O92.3 Agalactia
O92.4 Hypogalactia
O92.5 Suppressed lactation
O92.6 Galactorrhea
O92.70 Unspecified disorders of lactation
O92.79 Galactocele (Other disorders of lactation)
Z39.1 Encounter for care and examination of lactating mother (Excludes encounter for conditions related to O92.-)

Other
Z09 Encounter for follow-up examination after completed treatment (When the original reason for visit has resolved)

* Do not use any codes listed under the mother for the infant’s medical record

Additional Resource

The National Breastfeeding Center Payer Scorecard grades insurance companies on their breastfeeding support policies.