



Supporting Breastfeeding and Lactation: The Primary Care Pediatrician's Guide to Coding

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]

Billing for extra time spent on feeding problems at any PMS visit

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:

99391 **Z00.111**
99212-25 **P92.5**

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

Billing for any clinician's visit based on time

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

CPT guidelines allow for an office visit (ie, 99202-99215) to be billed based on time or medical decision making (MDM). You may bill based on time in lieu of MDM if time allows you to report a higher level of service.

Office Visits:

1. Time spent does not have to be continuous but must occur on the same day as the face-to-face encounter.
2. If reporting based on "time" count all the time on the encounter date, including pre- and post-service time spent on that patient, even if the patient is not present (excludes consultations).
3. You do not have to meet "time" requirements in the code descriptor to meet a code level if billing based on MDM.

Consultations:

1. If coding based on time, the documented time must show that more than 50% of the total time was spent in counseling and/or care coordination.
2. You may not count non-direct time, but time spent does not have to be continuous.

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

<i>New Patient</i>	<i>Time</i>	<i>Established Patient</i>	<i>Time</i>	<i>Outpatient Consult</i>	<i>Time</i>
99202	15-29	99212	10-19	99241	15
99203	30-44	99213	20-29	99242	30
99204	45-59	99214	30-39	99243	40
99205	60-74	99215	40-54	99244	60
				99245	80

[For example, if you spend 35 minutes face to face with an established infant and mother, you can report a 99214, even if your documentation for medical decision making only supports a 99213. You would choose time over MDM.]

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

* 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.

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**

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,

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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.

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.

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.

- Can be billed either as a new patient (**99202-99205**) or, if you have a request and will make a written report back to the requesting source, as a consult (**99241-99245**)

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

96164 Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes

+96165 Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes

96167 Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

+96168 Health behavior intervention, family (with the patient present), face-to-face, each additional 15 minutes

96170 Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes

+96171 Health behavior intervention, family (without the patient present), 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:

- **99441-99443** for services provided by a physician
- **98966-98968** for services provided by a qualified health care professional

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

HCPCS Codes

E0602 - Breast pump, manual, any type

E0603 - Breast pump, electric (AC and/or DC), any type

E0604 - Breast pump, hospital grade, electric (AC and/or DC) any type

¹ 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

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

³ American Academy of Pediatrics, Committee on Fetus and Newborn. Hospital stay for healthy term newborns. *Pediatrics*. 2010; 125:2 405-409; published ahead of print January 25, 2010. doi:10.1542/peds.2009-3119

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.