



# Integrating Breastfeeding into Your Primary Care Practice...

And getting paid!

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# Objectives

- Identify reasons for a breastfeeding baby to be seen at age 3 to 5 days and ways to bill for that visit
- Learn to bill based on time-breastfeeding visits may take longer
- Learn rules for billing for allied health providers

# Breastfeeding

- We are supposed to help
- Many barriers
- Many groups are telling us this is what we should be doing:

AAP

AAFP

ACOG

# Why we need to learn this...

- Healthier Kids
- Document: extent of care provided
- Establish that providing breastfeeding support is cost effective
- Be appropriately reimbursed for our time because it does take time to support breastfeeding

# Typical Well Baby Visit

17 minutes

# CPT Codes

- Current Procedural Terminology
- *Procedure* we do is E&M
  - evaluation and management (cognitive service)
  - Describe service provided, including intensity
  - Each code has a dollar value (that can vary)
  - Needs documentation in order to get paid
  - Tend to be 99...

# ICD-9 Codes

- International Classification of Diseases
  - Justifies procedure
  - Reason for encounter/diagnosis
  - Severity of illness
  - Medical necessity of services provided

# Common Codes for Breastfeeding

- Feeding problem or vomiting, newborn **779.3**
- Feeding problem, infant (>28 days) **783.3**
- Vomiting, infant (>28 days) **787.03**
- Breast-milk jaundice **774.39**
- Neonatal jaundice **774.6**
- Preterm jaundice **774.2**
- Dehydration, neonatal **775.5**
- Weight loss **783.21**
- Underweight **783.22**
- Slow weight gain, failure to thrive **783.41**
- Rapid weight gain **783.1**
- Fussy baby **780.91**
- Excessive crying **780.92**
- Infantile colic or intestinal distress **789.07**
- Change in bowel habits **787.99**
- Abnormal stools **787.7**
- Diarrhea **787.91**
- Ankyloglossia **750.0**
- High arched palate **750.26**

# Common codes for mothers

- Abscess, breast**675.14**
- Blocked milk duct **675.24**
- Breast engorgement, ductal**676.24**
- Burning pains, hyperesthesia**782.0**
- Ectopic or axillary breast tissue**757.6**
- Galactocele**676.84**
- Mastitis, infective **675.14**
- Mastitis, interstitial **675.24**
- 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**
- Disrupted sleep cycle**780.55**
- Fatigue**780.79**
- 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**

# Common Codes for Breastfeeding

- 676.84 (handy) other specified disorder of lactation- can be specified for codes that don't exist
- Always choose the most specific code possible
- Choose more than one when appropriate

# CPT: Time Based Coding

- Key to getting paid for education
- Ignore everything else
- As long as counseling or coordination of care accounts for more than 50% of time spent with patient/family
- Must be face-to-face physician (or other billable person) time
- Times become minimums
- Must be carefully documented
  - Time spent counseling >50%
  - Total time spent
  - Details of coordination of care/counseling

| <b>Established Patient Code</b> | <b>Total Minutes</b> |
|---------------------------------|----------------------|
| 99211                           | 5                    |
| 99212                           | 10                   |
| 99213                           | 15                   |
| 99214                           | 25                   |
| 99215                           | 40                   |

| <b>New Patient Code</b> | <b>Total Minutes</b> |
|-------------------------|----------------------|
| 99201                   | 10                   |
| 99202                   | 20                   |
| 99203                   | 30                   |
| 99204                   | 45                   |
| 99205                   | 60                   |

# Breastfeeding: Day 3 to 5

- The American Academy of Pediatrics recommends the 3 to 5 day visit
- To assess jaundice in all infants
- To address other early feeding issues

AAP Subcommittee on Hyperbilirubinemia. Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics*: 114:297-316

AAP Committee on Practice and Ambulatory Medicine. Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2000;105:645

AAP Committee on Fetus and Newborn. Hospital stay for healthy term newborns. *Pediatrics*. 1995;96:788-790

# Breastfeeding days 3 to 5

- Assess weight, hydration, jaundice
- Ooze enthusiasm
- Help baby grow and support mother's milk production
- Discuss normal behavior
- Ooze enthusiasm (did I say that?)

Bill visit as a first routine well visit or a follow-up for a previously identified problem

# Billing as a well visit

- No previous feeding problem noted in chart
- No other health problem identified
- Should be coded as first established well child visit

# Extra Time

- Could use 25 modifier
  - Indicates separate, significant E&M service
  - Feeding support is considered part of routine well baby care
  - Needs a separate paragraph
  - May require two co-pays
- Schedule a follow up visit. That follow up could be coded using follow up codes (99211-99215) related to that feeding problem

# Billing as a follow-up

- Might do because of insurance coverage
- Need to have reason for follow up documented
  - The earlier chart must have a an unresolved problem that requires follow up
  - A diagnosis code such as “newborn feeding problem” or “jaundice” must be in hospital’s record to establish need for follow up.
  - A telephone chart note would also count

# Billing as follow up

- Schedule with physician and use follow up codes
  - Code for problem if persistent
  - Use ICD-9 code V67.59 (resolved problem)
- Schedule as nurse visit with possible physician visit
  - If problem resolved: 99211, V67.59
  - Problem persists: physician visit and then use follow up codes

# Billing for Mother

- Taking history for both
- Examining breasts and baby
- Management and prescriptions for both
  
- Can bill as new patient the first time
- May require referral
- Two co-pays

# Consultation

- Requested: 99241-99245
  - May be E&M or time based
  - Requested by provider
  - Requires:
    - Request
    - Reason
    - Report (written)
- Confirmatory: 99271-99275
  - Family seeking their own consultation or second opinion
  - If billing for time, use new or established patient codes
  - Time based is ok for follow up

# Billing options for nurses and LCs

- Not covered by standard E&M ICD-9 codes
- Exception: 99211 (brief nurse visit)
- Possibilities for reimbursement
  - Joint consult with physician

# Joint consult with physician

- Nurse or LC
  - Spends longer time with patient
  - Takes history
  - Assess breastfeeding
  - Education
- Physician, NP, PA
  - Brief time in room
  - Reviews history
  - Documents exam
  - Confirms or adds to diagnosis
  - Management and prescriptions
  - Can bill on E&M complexity or actual physician time

- Document
- Document
- Document
- Document



# Cases

A 28-year-old first-time mother is seen for the evaluation of low milk supply. The mother was healthy prior to pregnancy and had no pregnancy complications and an unremarkable labor and delivery. The baby had gained weight well until the last 2 weeks when the mother noticed fewer wet diapers and a decrease in the volume of milk she was able to pump. She was taking no new medications and her recent thyroid test was normal. The mother's breast examination was normal. Pre- and post-feeding weights showed low transfer of milk with no nipple trauma and the baby had a coordinated suck and correct latch..



Her Edinburgh Postnatal Depression Scale screening test result was positive and she was referred to the practice's postpartum depression program. A total of 30 minutes of face-to-face time was spent with the mother, with 20 minutes spent discussing what antidepressants were compatible with breastfeeding, the effect of stress on milk supply, and a plan to increase her supply using relaxation, herbal supplements, and pumping. The physician decided to remain in close contact with the mother via telephone or e-mail until her milk supply increased

- This visit would be reported with code **99203** (new patient office or outpatient evaluation and management [E/M] service).
- The total face-to-face time between the patient and the physician was 30 minutes, with more than 50% of the time spent on counseling and coordination of care.
- The diagnosis would be reported with *International Classification of Diseases, Ninth Revision, Clinical Modification* code **676.84** (other specified disorders of lactation).

- If the patient had been referred from another physician or other appropriate source (eg, lactation consultant) for opinion or advice, an office or outpatient consultation code (**99243**) would have been reported.
- The physician would need to document the referral (oral or written request) in the patient's medical record and send a written report back to the referring physician or source.
- Code **96110** (developmental testing, limited) is the most appropriate code to report the Edinburgh screening test.
- Modifier **25** would be appended to the E/M service to identify the E/M as significant and separately identifiable from the screening test.
- These services would be reported under the mother's name. Depending on the payer, a referral may be required from her physician.

A 7-month-old boy, receiving most of his care through a clinic at the mother's workplace, is seen by his physician at the request of the clinic provider for evaluation of failure to thrive.

*History:* Established patient whose weight has decreased from the 75th percentile at 4 months of age to the 10th percentile 1 week ago based on the Centers for Disease Control and Prevention growth curve. He has been followed by the clinic for regular weight checks because of the decline in his percentiles without improvement. Uncomplicated pregnancy with vaginal delivery at term; breastfed exclusively with initiation of solid foods at about 6 months of age; neither parent is worried about appetite or growth and mother feels that her milk supply is adequate with no change in how much she pumps. All developmental milestones have been met; patient has maintained height and head circumference; there is no vomiting, diarrhea, or irritability. Mother is 64 inches tall; father is 69 inches.

*Physical examination:* Normal examination.

*Assessment:* After plotting the patient's weight since birth on the World Health Organization growth curves, weight shows consistent growth without evidence of faltering. Copy of his "correct" growth curve is given to parents with a copy for the workplace provider. Follow up as necessary. Parental education is provided to mother; total face-to-face visit = 25 minutes; total counseling and education = 18 minutes.

- This visit would be reported with *CPT* code **99214** (established patient office or outpatient E/M service) based on counseling time.
- The diagnosis code would be **783.41** (slow weight gain).
- The visit would not be reported as an office or outpatient consultation because there was no documentation of the request for opinion or advice and a written report was not sent back to the referring source.

# CDC

- Growth *reference*
- Survey of population of US
- Birth weight data from those states that include that info on the birth certificate

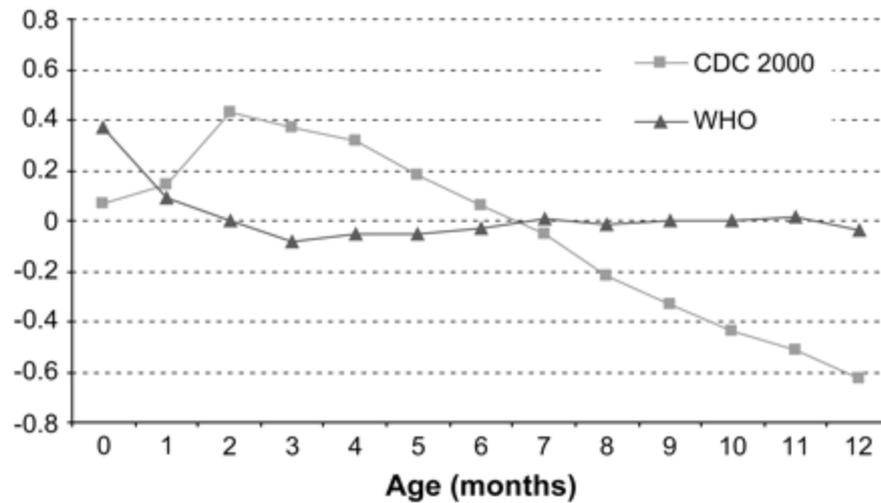
How kids in the US are growing

# WHO

- Growth *standard*
- Based on a world survey of breastfed infants in non-smoking homes
- Brazil, Ghana, India, Norway, Oman and the USA
- Different than CDC curves

How kids in the US *should be* growing

# Weight for age healthy bf





The patient is a 10 day old who comes in with her mother because of concerns about her stool output. She has not had a stool for about 36 hours. The baby has been breastfed and supplemented with formula. The mother was crying when she scheduled the appointment, saying that she dreaded the idea of breastfeeding because she has severe nipple pain but she thought the formula was causing problems with the baby.

The baby was born at term after an induced vaginal delivery. The mother stopped nursing her other two children because of nipple pain. With this baby, she had pain with latching in the hospital and started supplementing the baby with formula before discharge. The dyad had a visit at day 5 of age where a feeding was observed and the latch corrected. At that time, the mother had no nipple trauma and was able to nurse in the office without pain.



She was not able to replicate that latch at home but has continued to breastfeed despite the pain because she “doesn’t want to give up” with this baby. She has given the baby formula after she has finished breastfeeding. The baby has been consolable, afebrile and is voiding 5 times a day. Her physical exam is normal without evidence of thrush or ankyloglossia and she has regained her birth weight.

The mother’s nipples are red and abraded. Her breasts are not red or tender and no masses are palpable. The mother does not want to latch the baby on in the office because of anticipation of pain.

The mother was encouraged to use a pain reliever such as acetaminophen or ibuprofen and to apply a small amount of milk on the nipple after feeding. She did not want to feed the baby at breast at the present time. She agreed to pump in order to maintain her supply until the nipples had healed and to return in a few days to assess healing and discuss feeding at breast.

- This case required two separate billing codes: one for the mother and one for the baby. (this might require to separate co-pays, and may require a referral from the mother's physician).
- The baby was an established patient. The visit was billed as 779.3 (Feeding problem of newborn) and 99213.
- The mother's visit was billed as 676.14 (Nipple cracks or fissures) and 99202. The time spent with the mother was documented as 20 minutes, with 50% being counseling, documented as education.

# Thank you!!

Remember to email or fax your evaluations in to the CT AAP.

The first 50 physicians to return their evaluations will receive a

complimentary copy of Thomas Hale's

***Medications in Breastfeeding 2008***,

the most comprehensive and frequently

updated drug/breastfeeding reference

book, thanks to our generous grant

from CT DPH.

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