Lactation Support Services Coverage Under the Affordable Care Act

(or, Why Is Everything So Complicated Now?)
Today’s Agenda

Understanding the Implications of the ACA

- The Law
- (Commercial) Insurers Perspective
- Commercial Policies
- Credentialing & Contracting
- How Benefits are Covered
- Opportunities
Covering Lactation Services

The law states that Payers must cover, at no cost to the patient, ‘comprehensive lactation support and counseling, by a trained provider during pregnancy and / or in the postpartum period, and costs for renting breastfeeding equipment’. BUT:

What does “comprehensive lactation support” mean?
Who qualifies as a “trained provider”?
Why only cost coverage for “renting” equipment?
And does this apply to ALL ‘Payers’?
Does the ACA Apply to all ‘Payers’?

The Affordable Care Act primarily covers commercial insurance contracts.

- Does it apply to Medicaid?
  - It is NOT mandatory. States have to decide to cover USPSTF preventive services. There is incentive to do so, but few states have taken advantage of it. Medi-Cal DOES cover breastfeeding services.
  - Section 4106 provides that states who elect to cover all of the USPSTF grade A and B recommended preventive services with no cost-sharing shall receive an increased federal match for such services.

- Does it apply to the Military?
  - NO. It has its own rules and regulations with regard to services.
Lactation support services and breast pumps may be billed under mother’s or infant’s Medi-Cal number.

Lactation support services and breast pump coverage is available on the infant’s card even if the infant is past one year of age.

Breast Pumps are a benefit when prescribed by a licensed health care provider.

Medi-Cal providers are either licensed ‘providers’ or ‘practitioners’ working under a provider.

IBCLCs currently can work under a provider if not otherwise licensed.

See Karen Farley’s (WIC) presentation on coverage here:
http://ow.ly/t4iUY
The Commercial ‘Payer’ Perspective

ACA coverage requirement has created confusion for Payers:

- Lack of clear directives for coverage
- Lack of knowledge about services & equipment
- Undefined access need

For Payers, decisions based mostly on economics

- Coverage determined by need, access
- Complex process for creating and implementing policies

With few concrete answers, Payers have interpreted the law in a variety of ways...
Sample Policies
Aetna: The Groundbreaker (IBCLC)

- Opened its network to IBCLCs
- Identified specific billing codes to use
- Covers pump purchase cost when obtained through DME
- Hospital grade rental covered for medical necessity

Policies

- Pump policy on Provider site, service coverage not publicly defined
- Educated members about coverage
Aetna: Pump Policy (listed on provider site)

Aetna considers rental of a reusable breast pump medically necessary durable medical equipment (DME) when either of the following criteria is met:

- For the period of time that a newborn is detained in the hospital after the mother is discharged; breast pump rental is not considered medically necessary once the newborn is discharged; or
- For babies who have congenital disorders that interfere with feeding, a breast pump is considered medically necessary for up to 12 months of age.

Aetna does not cover breast pump purchase under standard Aetna benefit plans that are not currently subject to Department of Health and Human Services (DHHS) requirements for coverage of breast pumps. Non-reusable manual or electric breast pumps that are available commercially are not considered by Aetna to fall within the standard contractual definition of durable medical equipment in that they are normally of use in the absence of illness or injury.

Note: The following policy applies to new health plans and non-grandfathered plans that are currently subject to DHHS requirements for coverage of breast pumps, with coverage beginning in the first plan year that begins on or after August 1, 2012 (please check benefit plan descriptions):

- Aetna considers purchase of a manual or standard electric breast pump medically necessary during pregnancy or at any time following delivery for breastfeeding.
- Aetna considers purchase of a manual or standard electric breast pump medically necessary for women who plan to breastfeed an adopted infant when the above listed criteria are met.
- Aetna considers rental of a heavy duty electrical (hospital grade) breast pump medically necessary for the period of time that a newborn is detained in the hospital.
- For women using a breast pump from a prior pregnancy, a new set of breast pump supplies is considered medically necessary with each subsequent pregnancy for initiation or continuation of breastfeeding during pregnancy or following delivery.
- A replacement manual breast pump is considered medically necessary for each subsequent pregnancy, for breastfeeding during pregnancy or following delivery.
- A replacement standard electrical breast pump is considered medically necessary for subsequent pregnancies, for breastfeeding during pregnancy or following delivery, for members who have not received a standard electric breast pump within the previous three years or if the initial electric breast pump is broken and out of warranty.
- Aetna considers purchase of heavy duty electrical (hospital grade) breast pumps not medically necessary.
Aetna: PUMP Policy (Member site)

Pump coverage marketed to members.

If you decide to breast feed your new baby, and want to buy a breast pump and supplies, you can purchase directly from the Aetna participating breast pump suppliers below.

If your plan covers in network women's preventive services at no cost share, you can get a breast pump from the suppliers below at no out-of-pocket cost. You will not pay any co-pay, coinsurance or deductible.

Even if your plan does not cover women's preventive services with no cost share, you can still get a breast pump from the suppliers listed below at an Aetna discounted rate.

The Women's Preventive Health Breast Feeding Benefit includes:

- a standard electric pump (non-hospital-grade) within 60 days of birth, once every three years, or
- a manual breast pump within 12 months of birth, if you have not received an electric or a manual breast pump in the last three years, and
- another set of breast pump supplies if you get pregnant again before you are eligible for a new pump.

What about services?
Aetna: Services Policy (Member site)

Service coverage promoting Pediatricians and OB/GYNs first, then in-network Lactation Consultants:

Plans with the women's preventive services benefit also cover up to six visits with a lactation consultant if you need support with breast feeding. Your in-network ob/gyn or pediatrician may offer these services through their office. You may also check our online provider directory on Aetna Navigator®. Or call the Member Services number on your Aetna ID card to find a lactation consultant in our network.
## Aetna: Billing Codes

<table>
<thead>
<tr>
<th>Preventive Coverage Category</th>
<th>Associated CPT/HCPCS Code(s)</th>
<th>Covered preventive diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation classes, non-physician provider,</td>
<td>S9443</td>
<td>Covered as preventive for any diagnosis</td>
</tr>
<tr>
<td>per session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive medicine, individual counseling</td>
<td>99401 - 15 min</td>
<td>ICD-9 Codes considered preventive for this category:</td>
</tr>
<tr>
<td></td>
<td>99402 – 30 min</td>
<td>• pregnancy (640.00-677, V22-V24.2, V27-V28.9)</td>
</tr>
<tr>
<td></td>
<td>99403 - 45 min</td>
<td>• lactation (676.44, 676.54, 676.84, V24.1)</td>
</tr>
<tr>
<td></td>
<td>99404 – 60 min +</td>
<td>• feeding problem in newborn (779.3, 783.3)</td>
</tr>
<tr>
<td>Preventive medicine, group counseling</td>
<td>99411 - 30 min</td>
<td>ICD-9 Codes considered preventive for this category:</td>
</tr>
<tr>
<td></td>
<td>99412 – 60 min</td>
<td>• pregnancy (640.00-677, V22-V24.2, V27-V28.9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• lactation (676.44, 676.54, 676.84, V24.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• feeding problem in newborn (779.3, 783.3)</td>
</tr>
<tr>
<td>Office or outpatient visit for evaluation</td>
<td>99201-99203</td>
<td>ICD-9 Codes considered preventive for this category:</td>
</tr>
<tr>
<td>and management (E&amp;M) – New Patient</td>
<td>Codes determined by time,</td>
<td>• lactation (676.44, 676.54, 676.84, V24.1)</td>
</tr>
<tr>
<td></td>
<td>complexity and review of</td>
<td>• feeding problem in newborn (779.3, 783.3)</td>
</tr>
<tr>
<td></td>
<td>systems</td>
<td></td>
</tr>
<tr>
<td>Office or outpatient visit for evaluation</td>
<td>99211-99214</td>
<td>ICD-9 Codes considered preventive for this category:</td>
</tr>
<tr>
<td>and management (E&amp;M) – Established Patient</td>
<td>Codes determined by time,</td>
<td>• lactation (676.44, 676.54, 676.84, V24.1)</td>
</tr>
<tr>
<td></td>
<td>complexity and review of</td>
<td>• feeding problem in newborn (779.3, 783.3)</td>
</tr>
<tr>
<td></td>
<td>systems</td>
<td></td>
</tr>
</tbody>
</table>
UHC: Nice Guy Model?

- Allows in-network providers to supply pumps as well as DME
- Only licensed in-network providers can provide services
- Identified specific support and counseling codes but must be used with specific dx codes
- No payment when performed as part of the well visit

Policies

- Comprehensive policy on Provider site and education on Consumer sites including obtaining pump from provider
BF services payable with well visits? Great!
### Primary Care Interventions to Promote Breastfeeding

**USPSTF Rating (Oct. 2008): B**

The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.

**Also see Expanded Women’s Preventive Health table below.**

**Code(s):**

- n/a

**Claims Edit Criteria:**

- Included in primary care or OB/GYN office visits.

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**Service:**

A date in this column refers to the date the USPSTF announcement was released.

**Note:** ICD-10 codes are effective 10/1/14.
UHC: Policy #2

This is how (stand-alone) BF services and equipment need to be coded:

<table>
<thead>
<tr>
<th>Breastfeeding Support, Supplies, and Counseling</th>
<th>Support and Counseling:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Procedure Code(s): S9443, 99241 – 99245, 99341 – 99345, 99347 – 99350 (Also see the codes in the Wellness Examinations section of the Preventive Care Services table above.)</td>
</tr>
<tr>
<td></td>
<td>Equipment &amp; Supplies:</td>
</tr>
<tr>
<td></td>
<td>Procedure Code(s): E0603, E0604, A4281, A4282, A4283, A4284, A4285, A4286 (NOTE: “RR” rental modifier is required for E0604.)</td>
</tr>
<tr>
<td></td>
<td>Diagnosis Code(s): V24.1 (Code V24.1 is required for all Equipment &amp; Supply procedure codes listed above.)</td>
</tr>
</tbody>
</table>
### Expanded Women’s Preventive Health

These are the requirements of Health and Human Services for plan years that begin on or after 8/1/12. For additional services covered for women, see the Preventive Care Services table above. Certain codes may not be payable in all circumstances due to other policies or guidelines.

<table>
<thead>
<tr>
<th>Service:</th>
<th>Code(s):</th>
<th>Claims Edit Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breastfeeding Support, Supplies, and Counseling</strong></td>
<td><strong>Support and Counseling:</strong> Procedure Code(s):</td>
<td><strong>Support and Counseling:</strong></td>
</tr>
<tr>
<td></td>
<td>• S9443</td>
<td>• The Diagnosis Code listed in this row is required for 99241 – 99245, 99341 – 99345, and 99347 – 99350</td>
</tr>
<tr>
<td></td>
<td>• 99241, 99242, 99243, 99244, 99245</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 99341, 99342, 99343, 99344, 99345</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 99347, 99348, 99349, 99350</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Also see the codes in the Wellness Examinations section of the Preventive Care Services table above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Diagnosis Code(s):</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ICD-9: V24.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ICD-10: Z39.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Breast Pump Equipment &amp; Supplies:</strong> Procedure Code(s): Hospital Grade Rental:</td>
<td><strong>Breast Pump Equipment &amp; Supplies:</strong></td>
</tr>
<tr>
<td></td>
<td>• E0604</td>
<td>• Code E0604 is allowed when the “RR” rental modifier is attached.</td>
</tr>
<tr>
<td></td>
<td>Personal Use Electric:</td>
<td>• The Diagnosis Code listed in this row is required for E0603, E0604 and A4281 – A4286.</td>
</tr>
<tr>
<td></td>
<td>• E0603</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Breast Pump Supplies:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A4281, A4282, A4283, A4284, A4285, A4286</td>
<td></td>
</tr>
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<td></td>
<td><strong>Diagnosis Code(s):</strong></td>
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</table>
The UGLY Model: Minimum Coverage

- Payers complying with the bare minimum in their interpretation of the law
- Covering hand pumps only
- Little promotion of the coverage to members
- No guidance on coding
- Bundled payment for in-network providers

Policies

- Undefined and usually unpublished
Credentialing & Contracting

Or, Why Can’t We All Just Get Paid?
Why Can’t ALL LCs Get Paid by Insurers?

- Commercial Insurers have ‘networks’ of providers
- These providers have to be credentialed and contracted per certain rules and regulations
- Most providers admitted to Payer networks are licensed professionals
What is 'Credentialing'?

- The credentialing process is an industry-standard systematic approach to the collection and verification of a practitioner applicant’s professional qualifications.
- The National Committee on Quality Assurance (NCQA) sets many of these requirements.
- Payers MUST adhere to these standards.
Why is 'Credentialing' Important?

- The credentialing process evaluates the qualifications of practitioners who seek to provide care for its members and is completed before a practitioner is accepted for participation into a Payer's network.

- The assessment and verification of these qualifications helps to confirm that the practitioner meets certain criteria relating to professional competence and conduct in several areas.

- It also includes review of relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background.
Why Do Insurers Have to 'Credential'?

- Insurers are responsible for credentialing all independent practitioners with whom they contract, or employ, including physicians, dentists, chiropractors, podiatrists and others.

- They are not required to credential practitioners who practice exclusively within another organization, such as the inpatient hospital setting, or free standing facilities like mammography centers, urgent care centers, or surgi-centers because they are under contract with that organization and have no independent relationship with the insurer.

Continued . . .
Why Do Insurers Have to 'Credential'?

- Non-physician practitioners undergo a credentialing process much like that of physicians. The differences lies in the requirements and therefore in the verification of select data.
  
  - For example, chiropractors are not board certified and do not require DEA or CDS certificates.
  
  - For the specific differences among the professional groups and the requirements of each, the NCQA Surveyor Guidelines is often used, which outlines what is required for each type of practitioner and where to access such information.
  
  - Lactation consultants are not covered in these guidelines, which means new territory altogether for Payers . . .
Why Do Insurers Have to 'Credential'?  

To review, Payers are required to:

- Evaluate the qualifications of providers with whom they credential
- Ensure that each practitioner meets certain criteria relating to professional competence and conduct
- Are responsible for credentialing all independent practitioners with whom they contract
- Confirm that the provider is in good standing with state and federal regulatory bodies
- And ensure each provider has been reviewed and approved by an accrediting body

This explains why some insurers have chosen to credential IBCLCs but not other types of LCs; and why many have decided not to recognize non-licensed providers of lactation services at all . . .
What is 'Contracting'?

- Once credentialed successfully, you are eligible to become a ‘network’ (or ‘in-network’) provider.
- To be considered 'in-network' or a 'participating provider' you must sign a contract.
- The contract spells out a number of terms including things like:
  - Initial term of the contract
  - Adhering to policies and procedures
  - Claims and Payment rules
  - Termination of the contract
  - Breach of contract
What is 'Contracting'?

Payment Rules:

- The contract stipulates that you MUST accept the insurance company's payment as payment in full.

- This means that you CANNOT bill your patient for the difference between your typical rate and the 'contracted rate' (the rate the insurer pays you)

- Rates are different in different regions of the country
Can You Join Any Network?

- Very few insurers will credential and contract with non-licensed providers (or providers that have licenses that are not MD, DO, DDS, APRN, etc)

- Aetna is one of the few insurers credentialing and contracting lactation consultants, but will only do so for those with the IBCLC designation
Benefits & Claims

Or, Why Do Payers All Pay Differently?
The Payer Perspective

Everything is based on economics

- Consumers and employers pay insurers to provide 'benefits'
- Benefits are regulated by a number of factors – government (such as mandatory coverage of certain care under the Accountable Care Act), medical efficacy and demand
- Most insurers are 'for-profit' and have shareholders to satisfy
- In order to maximize profit, they have to keep costs as low as possible (yes, you are a 'cost') by paying as little as possible for as few things as possible
What Determines Benefits?

Benefits

- Benefits are typically determined by need, access, regulation
- Benefits are also 'designed' based on employer needs and demands
- Many large employers are 'self-funded' versus smaller purchasers who pay premiums so that insurers are the ones 'at-risk'
  - 'Self-funded' means that an employer uses the insurance to process and pay claims and the insurer charges back the exact cost plus a profit for that service
  - 'At-risk' means that the insurer charges a set rate for premiums and takes on the risk if claims costs are higher than what was paid in premiums
How Are Claims Paid?

Claims

- Claims are paid based on a plan's **policies** and employer's (or plan type’s) **benefit** design
  - Example, an employer may 'carve' certain things out of its policy, like bariatric surgery
  - PPO plans often allow for out-of-network coverage of services

- There is a complex process for creating and implementing policies
  - Involves researching medical evidence to support coverage
  - Requires understanding how services and procedures will be used
  - Feeds the claims 'adjudication' systems
How Are Claims Paid?

Claims, continued

- Policies are what determine what gets paid, to whom, and how

- Policies define criteria for coverage (payment) and it is this 'logic' that is used to set up claims algorithms in complex claims engine databases

- Claims engines are also required to follow certain rules with regard to things like modifiers and bundling, usually National Correct Coding Initiative Edits (NCCI Edits)
A Note About ‘Grandfathered’ Plans

- Grandfathered plans are those that were in existence on March 23, 2010 and have stayed basically the same.
- ‘Staying the same’ means no increase to rates, no changes in plan benefit design, no change in cost-share
- Grandfathered plans do not have to cover preventive care (including BF services) for free, or in some cases, cover them at all
Can LC's Get Payment for In-Hospital Services?

Insurers consider in-hospital services rendered by organizational employees to be included in payment for the hospital stay.

- Can I get paid for rendering services to patients in-hospital?
  - Yes. But only as an independent contractor and seeing patients ‘independently’ of that organization. You would bill CPT codes for services and list the place of service as ‘in-hospital’

- How else can LCs get paid for rendering services in-hospital?
  - Set up an OUT-PATIENT breastfeeding center at the hospital and ‘round’ on Moms and babies
Many Payers allow ‘incident-to’ billing

- Services and supplies properly provided and billed incident-to an in-network physician’s (or licensed non-physician practitioner’s) services are paid at 100 percent of the network fee schedule.
- This provides an opportunity for practices to contract with LCs
- Charges are billed out under the physician
- Physician does not need to spend time meeting with the patient(s) once specific guidelines are adhered to
Incident-To Billing Rules

- Certain rules need to be followed:

1. The patient must be ‘established’ (meaning has previously been seen by the physician / licensed practitioner), with an established problem or complaint

2. Services must be medically necessary and appropriate in the physician office

3. Direct supervision is required
   - Direct supervision means the physician must be present in the office suite and immediately available to provide assistance and direction.

Restrictive but can work well as physicians do not have to tie up any of their time.
Some patients assume that because the ACA regulation has gone into effect, that it means that they are covered for your services

Wrong! Every patient’s benefits package is different.

You should only submit to plans in which you participate. For all other coverage, have your patients pay you and provide your patients with a superbill or completed HCFA to submit.

But in some cases, a Payer may not allow a patient to submit directly. Submit on their behalf, but make sure to collect payment in full at time of service.
Opportunities

Payers need education and assistance

- Clarification on what is needed, supported by evidence
- Presentation of a comprehensive policy detailing how, when and why
- Guidance on coverage criteria, provider types, coding and equipment
- Presented as a comprehensive policy for wholesale adoption

Model Policy

Use Every Resource You Can

Working with Insurance Companies is complicated

- Utilize your associations to find valuable information
- Utilize Payers websites and Google to find policies
- Enlist the help of your patients
  - Encourage them to determine what their benefits are, and how to go about submitting charges
- Network!
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