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The Affordable Care Act: What's New with Breastfeeding Support?

(or, The Law Says Breastfeeding Services Are a Payable Benefit, So Why Can't I Get Paid?)

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Chair, Board of Directors of the United States Breastfeeding Committee
Executive Director of The National Breastfeeding Center
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Today's Agenda

Part 1: Why Is It So Complicated?

- What the ACA Law Really Says
- (Commercial) Insurers Perspective
- Commercial Policies

Part 2: Why Can't We All Just Get Paid?

- Credentialing & In-network Status
- How Insurance Benefits Work
- How to Get Paid By Insurers (Or Not)

Part 3: A Look at Current Policies & Trends

- Payer Policy Scorecard
- Helping Your Patients to Get Covered

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'?**

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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.
  - 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 but is now changing policy to include coverage

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. . .

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Why Can't We All Just Get Paid?

Understanding Credentialing & Billing

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
- Many plans have 'in-network' benefits only, meaning that services provided by out-of-network providers are not covered
- Most providers admitted to Payer networks have to be **licensed professionals**
- Many plans will not recognize (or pay) non-licensed providers

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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 Credential verification certificates.
  - For the specific differences among the professional groups and the requirements of each, the National Committee on Quality Assurance (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 . . .

Continued . . .

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, CLC's but not other types of LCs; and why many have decided not to recognize non-licensed providers of lactation services at all . . .

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 or CLC designation

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Benefits & Claims

Or, Why Do Payers All Pay Differently?

The Payer Perspective (Health Insurer)

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 insurer 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)

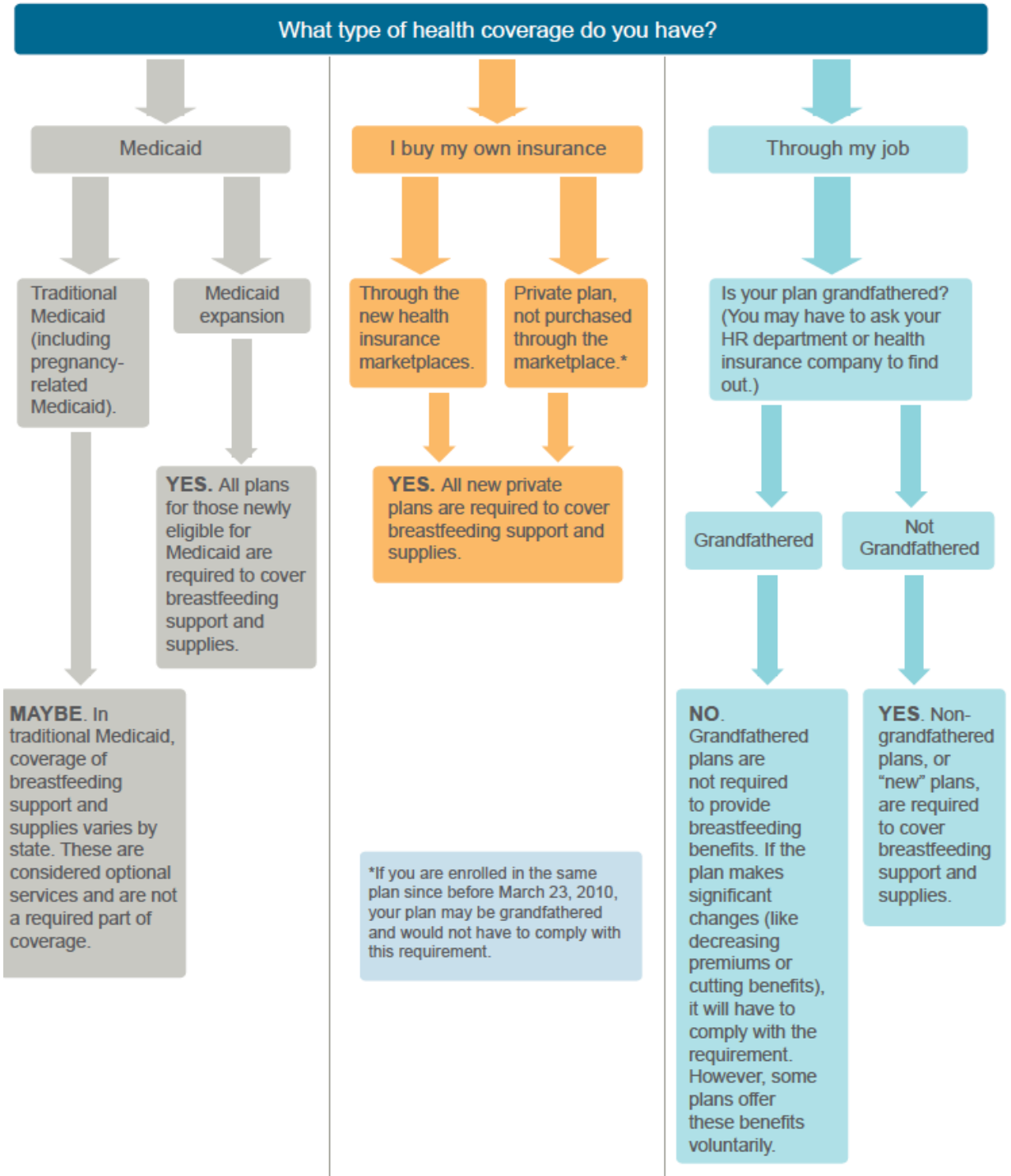
A Note About 'Grandfathered' Plans

- 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**

From the
NLWC New Moms Breastfeeding Toolkit

Does my health insurance have to cover breastfeeding supplies and support without cost-sharing?

http://www.nwlc.org/resource/new-benefits-breastfeeding-moms-facts-and-tools-understand-your-coverage-under-health-care-



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Getting Paid by Insurers

Getting Paid 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

Getting Paid for Services Rendered in Physician Offices

- 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

- But 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 (this needs to be the lactation issue)

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 much of their time.

Incident-To Billing Rules

How it works:

- The physician sees the Mom & Baby at the first in-office well visit and establishes (notes in the record) a lactation issue.
- The lactation consultant can then render 'follow up' care that is 'incident-to' that visit; either directly after the physician has seen the patient for the well visit, and / or as on-going lactation visits **provided that the diagnosis does not change**.
  - If the initial diagnosis changes, the physician must see the patient before you can continue care, as your services are incident-to whatever services the physician provides.

Incident-To Billing Rules

The take-away:

- In order for services of a 'Non Physician Provider' to be covered as 'incident to' the services of a physician, the services must be an integral, although incidental, part of the physician's professional services, and they must be performed under the physician's direct supervision.

Incident-To Billing Rules

How you get paid:

- Lactation Consultant can be employed
  - The physician's office would pay you as an employee for hours worked
- Lactation Consultant can be an independent contractor
  - The physician's office pay a set rate, either per patient or per hour (never set a percentage of payments!)

In either case the physician bills out your services as 'incident-to' their initial office visit with the Mom and Baby.

Billing and Coding

- Current Procedural Terminology (CPT) Codes
- CPT codes-billing for services in outpatient setting evaluation and management services
- International Classification of Disease Diagnoses
- ICD-9 Codes soon to be ICD-10 Codes (October,2015)

The CPT code tells the insurer "what" was done (i.e. type of visit), and the ICD-9 tells "why" or the diagnosis

Codes

The CPT codes for new patients (99201-99205) and for established patients (99211-99215) are usually at a level 4 or 5 for lactation visits

Requires Documentation

Chief Complaint

History of Present Illness, Fam Hx, Soc Hx

Review of Systems

Exam findings,

Assessment and Plan

Aetna: Billing Codes

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

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Payer Policy Scorecard

The Who's Who (and Who's Not) of Paying Payers

Latest Policy Scorecard 2014

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What was Measured in 2014?

Types of Services(classes, counseling, home visits, coverage of donor milk)

Types of providers covered (existing in-network providers, certified lactation care providers)

Types of Pumps(manual, electric, rental grade)

Criteria or restrictions on coverage (premature or compromised infants)

Accessibility(in network only for services, pumps available only through DME vendors, etc)

Helping Your Patients to Get Coverage

Q: What if my insurance company doesn't have any lactation consultants or breast pump supplier in-network?

A: If your insurance company doesn't have any lactation consultants or breast pump providers in-network, the insurance company must cover services from an out-of-network provider without cost-sharing. Federal guidance makes clear that "if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service."[1] If your insurance company does not have providers in its network to provide breastfeeding equipment or lactation counseling, you must be able to go out-of-network, the item or service must be covered; and covered at no cost-sharing.

New Benefits for Breastfeeding Moms: Facts and Tools to Understand Your Coverage under the Health Care Law

May 08, 2014

As part of women's preventive services under the ACA, new plans are required to cover breastfeeding support, supplies, and counseling. This is a significant step forward in making breastfeeding more accessible and affordable for millions of Americans.

This toolkit is designed for women, advocates, community-based organizations and health care providers to provide information on the coverage of breastfeeding support, supplies, and counseling in the health care law and offer tools to use women encounter problems with this coverage. We have also provided detailed instructions on how to call insurance companies and how to file an appeal if the plan denies coverage. The toolkit includes draft appeal letters tailored to commonly encountered scenarios.

If you have any questions or need further guidance, contact the National Women's Law Center at 1-866-745-5487 or prevention@nwlc.org. We are interested in hearing from you. Please let us know if you use this toolkit to obtain coverage successfully.

Document(s): Breastfeeding Toolkit May 2014
Sample Letter for Lactation Consultant
Sample Letter No Coverage Policy

http://www.nwlc.org/resource/new-benefits-breastfeeding-moms-facts-and-tools-understand-your-coverage-under-health-care-

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