Impacts of Breastfeeding Support, Supplies, and Counseling on Health Insurance Premiums and Costs

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BACKGROUND AND INTRODUCTION

The Special Supplemental Nutritional Program for Women, Infants and Children (WIC) is a federal program which provides grants to states for low income women and children to provide supplemental food, health care referral, nutritional education, breastfeeding support and services, and nutritional support to infants and children up to age five at nutritional risk. The California Department of Public Health administers the WIC program working closely with 83 WIC agencies serving about 1.16 million participants throughout the state.[1] California WIC Association (CWA) is a nonprofit organization that is made up of local agencies and organizations that obtain WIC grants to directly serve the population. CWA provides education and advocacy, research and policy analysis related to nutritional support programs, including breastfeeding supports, supplies, and counseling benefits. As part of their breastfeeding education and advocacy efforts, CWA works with local, state, and federal partners to ensure that low-income women receive breastfeeding support and assistance throughout the prenatal and postpartum period, when the mother is most likely to need assistance.

Breastfeeding has been documented to reduce risk of certain infancy and childhood illness, such as acute otitis media, lower respiratory infections, and gastrointestinal tract infections. Studies also suggest associated positive maternal health outcomes such as reduced risk of breast and ovarian cancer.[2] [3] The American Academy of Pediatrics recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary foods are introduced for about one year.[4]

Breastfeeding support, supplies, and counseling are required to be covered under the Patient Protection and Affordable Care Act (ACA) of 2010. Specifically, the ACA requires all non-grandfathered health plans, to provide coverage for breastfeeding support, supplies, and counseling through Section 2713, which requires coverage of specific preventive services. The Women's Preventive Services Guidelines, supported by the Health Resources and Services Administration, clarifies that certain breastfeeding support, supplies, and counseling must be covered. These include, "comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding."[5] These services must be covered in conjunction with each birth. Comprehensive lactation support and counseling services are available at no cost share. The breastfeeding supplies benefit includes the cost of breast pump rental and purchase for approved equipment at no cost share.

As the federal government is considering various "replace, repeal, and repair" scenarios of the ACA, CWA is interested in informing policymakers of the impact of this benefit coverage on health insurance premiums. CWA, through Ursa Consulting (Ursa) as a prime contractor, has engaged Milliman, Inc. to

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[1] California Department of Public Health (CDPH) 2016. Women, Infants, and Children Program. Available at: http://www.cdph.ca.gov/programs/wicworks/Pages/default.aspx/

[2] Patnode CD, Henninger ML, Senger CA, Perdue LA, Whitlock EP. Primary Care Interventions to Support Breastfeeding: An Updated Systematic Review for the US Preventive Services Task Force. Evidence Synthesis No. 143. AHRQ Publication No. 15-05218-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2016.

[3] Patnode CD, Henninger ML, Senger CA, Perdue LA, Whitlock EP. Primary care interventions to support breastfeeding: an updated systematic review for the US Preventive Services Task Force. *JAMA.* 2016.

[4] American Academy of Pediatrics. Policy Statement. Breastfeeding and the Use of Human Milk. *Pediatrics.* 2012.

[5] HRSA. Women's Preventive Services Guidelines. 2016. Available at: https://www.hrsa.gov/womensguidelines2016/index.html.

estimate the impact of breastfeeding support, supplies, and counseling on health insurance premiums and costs.

CALIFORNIA MEDI-CAL COVERAGE

In California, all Medi-Cal members have comprehensive coverage for breastfeeding support, supplies, and counseling services at no cost share when services are provided through approved providers and suppliers. In addition, Medi-Cal managed care plans, which cover about 80% of all Medi-Cal members, have maternity-related care management programs that include policies to drive improvements in breastfeeding rates and outcomes. For example, Molina HealthCare, a Medi-Cal managed care plan serving Imperial, Los Angeles, Riverside, Sacramento, San Bernardino and San Diego counties directs its Perinatal Support Staff to “counsel breast-feeding mothers on dietary needs of breast-feeding and management of specific breast-feeding problems i.e. address member’s individual concerns and needs, refer high-risk members for appropriate intervention.”[6] Anthem Blue Cross, a Medi-Cal managed care plan serving 28 counties in California, has a case management and care coordination program which includes promotion, education, counseling, and provision of medically necessary breastfeeding related services.

Eligible Medi-Cal members may be referred to the California WIC program. For example, Molina may refer eligible members to the WIC program within four weeks of their first prenatal visit. Members who are enrolled in WIC receive food vouchers on a monthly basis. WIC participants may also attend monthly health education and nutritional classes. These health education classes may also include breast-feeding support and counseling classes. Anthem Blue Cross also requires its Medi-Cal contracted providers to refer pregnant and breastfeeding members to the WIC program in their area.

LA Care, a Medi-Cal managed care plan operating in Los Angeles County under a Two-Plan Model, considers the WIC program a carve-out and directs its contracted providers to evaluate members and refer eligible members to the Los Angeles County Public Health Services WIC Program. Newly pregnant, breastfeeding, or postpartum women or a parent of a child up to age five may be eligible. The referring provider to the WIC program must document certain information in the members’ record:

- A current hemoglobin or hematocrit laboratory value
- Present height and weight
- Confirmation of the pregnancy date
- Birth weight and length for infants
- For small or pre-term infants, documentation of the gestational age[7]

Medi-Cal managed care members can also self-refer to the WIC program.

In California, there is also a program called the Comprehensive Perinatal Services Program (CPSP) administered by the Maternal, Child and Adolescent Health Division of the California Department of Public Health which provides a wide range of services to Medi-Cal pregnant women, from conception to 60 days postpartum. This program’s goal is to reduce morbidity and mortality among mothers and newborns. It was

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[6] Molina HealthCare of California. 2016. Medi-Cal Managed Care Provider Manual. p. 111 Available at: http://www.molinahealthcare.com/providers/ca/PDF/MediCal/provider-manual.pdf.

[7] LA Care Health Plan. 2017. LA Care Medi-Cal Provider Manual. Available at: https://www.lacare.org/sites/default/files/mcla-provider-manual-2017.pdf.

established in 1984, and became a Medi-Cal benefit in 1987. Medi-Cal managed care plans are to provide access to services that are comparable to services offered to pregnant Medi-Cal members. These services include comprehensive perinatal services, initial assessment, trimester reassessments, postpartum assessment, interventions, and follow-up services, individual and group education, nutrition, health education, psychosocial services, case coordination, prenatal vitamin/mineral supplements, and referrals to WIC.[8]

RESULTS

We analyzed administrative claims data for the commercial population to estimate the use of support, supplies, and counseling services, and adjusted the data to reflect the higher utilization rates in the Medi-Cal market. We relied on the most recently available Medi-Cal fee schedules to determine the reimbursement rates for these services.[9] We then estimated the per member per year (PMPY) costs and the proportion of total Medi-Cal enrollee healthcare expenditures attributable to breastfeeding support, supplies, and counseling services.[10]

IMPACTS ON TOTAL ENROLLEE HEALTHCARE EXPENDITURES

Results of our analysis for Medi-Cal are provided in Exhibit 1: Proportion of Total Enrollee Healthcare Expenditures: Breastfeeding Support, Counseling, and Supplies, Medi-Cal, 2017.

[8] CDPH. 2017. Comprehensive Perinatal Services Program. http://www.cdph.ca.gov/programs/cpsp/Pages/default.aspx

[9] Medi-Cal Fee Schedules are published by the Department of Healthcare Services and are available here: http://www.dir.ca.gov/dwc/OMFS9904.htm. The most recently available schedule is dated March 1, 2017.

[10] Per member per year (PMPY) refers to ratio of healthcare costs divided by the number of members in a particular group over an annual basis. For example, let’s say a health insurer paid $500,000 in claims for a particular service for the members using the service in one year. Let’s say the total number of members in that group is 10,000. Then the PMPY is $50 and the total per-member-per-month (PMPM) is $50/12 months = $4.17.

Exhibit 1: Proportion of Total Enrollee Healthcare Expenditures: Breastfeeding Support, Supplies, and Counseling, Medi-Cal, 2017

Category	Procedure	Related Diagnosis Codes	Util/1,000	Average Allowed	PMPY	Percent of Total Enrollee Expenditures
Breastfeeding Support	**Individual & Group Preventive Counseling**	Pregnancy	0.164	$7.16	$0.00	0.0000%
		Lactation and breastfeeding problems	0.063	$58.46	$0.00	0.0001%
		Feeding problem in newborn	0.048	$7.16	$0.00	0.0000%
	Office or Outpatient Evaluation & Management	Lactation and breastfeeding problems	2.944	$30.28	$0.09	0.0017%
		Feeding problem in newborn	9.331	$33.12	$0.31	0.0060%
	Office Consultation	Lactation and breastfeeding problems	0.029	$81.22	$0.00	0.0000%
	Home Visits	Lactation and breastfeeding problems	0.096	$66.67	$0.01	0.0001%
	Self Management Education & Training	Lactation and breastfeeding problems	0.000	$0.00	$0.00	0.0000%
	Lactation Class		0.000	$0.00	$0.00	0.0000%
Breast Pumps and Supplies	**Breast Pumps (Manual & Electric)**	Post Partum Care Lactation	6.878	$92.66	$0.64	0.0123%
	Other Equipment & Supplies		2.900	$16.62	$0.05	0.0009%
	Breast Pumps (Hospital Grade)	Modifier RR*	0.822	$81.60	$0.07	0.0013%
Total					**$1.16**	**0.0226%**

*RR indicates the rental rate

For the Medicaid population, the total cost for breastfeeding support, supplies, and counseling benefit represents a small portion of Medi-Cal coverage—approximately 0.0226% of total per-enrollee expenditures. As a point of reference, if the total per-enrollee expenditures for a Medi-Cal enrollee was $430 per month, or $5,160 per year, approximately $1.16 per member per year may be attributed to this benefit.

A few observations are worth noting:

- Our data sources will only capture services for which there was a submitted claim. If mothers directly obtain lactation counseling services, self-management or training, or breast pumps and supplies outside of insurance, these will not be captured in the claims. In addition, lactation support provided by peer counselors will not be captured in the claims.
- We did not find any material utilization of self-management education and training, or lactation classes for this population. Utilization rates for these services may be higher for the Medi-Cal population.
- Our utilization estimates may vary from statewide utilization rates for Medi-Cal members since some of these services may be provided directly by WIC.
- We are not modeling the behavioral effects of a repeal of ACA related statutes or regulations requiring coverage of these services. Because a benefit is no longer mandated does not mean that benefit will no longer be offered by Medi-Cal. A statutory or regulatory change to effectively repeal

the mandate to cover these services is unlikely to eliminate use or costs related to these services entirely. Modeling the effects of statutes or regulations is complex and requires developing assumptions regarding California state legislative and regulatory activity, and health plan, and consumer behavior.

- As noted in the Exhibit, most of the utilization for breastfeeding support, supplies, and counseling is for breast pumps and supplies. Meanwhile, there was lower than expected utilization (in terms of visit per 1,000) for lactation support services. This may be because claims are likely to be consistently coded for breast pumps and supplies whereas lactation-related counseling and support services are less consistently captured.
- Our analysis relied on commercial data sources with adjustments made to reflect Medi-Cal's demographics and resulting utilization differences. The authors did not have access to credible Medi-Cal encounter data for this analysis. However, there may be limitations to Medi-Cal encounter data as well:
  - Services provided through the WIC program, such as counseling, self-management education, and training, may not be captured in Medi-Cal encounter data.
  - Medi-Cal managed care plans may be providing certain lactation classes, education, and self-management training services through the plans' maternity care management program. Because maternity-related care management program payments are part of the kick payments that are made to Medi-Cal managed care plans in addition to the Medi-Cal managed care plan capitated rate (and are based on the number of deliveries) services that are offered through care management services may not be captured in the encounter data.

COST OFFSET

The reduced risk for certain conditions that are associated with breastfeeding may result in reduced healthcare costs for both the child and the mother. The literature indicates potential pediatric health outcome effects related to several conditions including: acute lymphoblastic leukemia, acute otitis media, asthma, atopic dermatitis, gastrointestinal infection, and even chronic conditions such as obesity and diabetes.[11] Potential maternal health outcomes include reduced risk for breast cancer, pre-menopausal ovarian cancer, high blood pressure, and heart attack.[12]

Payers and public and private purchasers are interested in understanding the potential near-term savings associated with a covered benefit, if it is quantifiable. Not many healthcare interventions have well-studied, quantifiable savings in the near term, however in the case of breastfeeding there are studies establishing the link to breastfeeding and a reduction in certain healthcare costs. To estimate the potential near term (within 1 year) impacts of any successful breastfeeding, we relied on Bartick and colleagues' comprehensive study on the economic burden of suboptimal breastfeeding. This study included a review of prior economic studies, including prior simulation studies, to develop economic projections. According to their research, direct medical costs for four conditions could be avoided within one year with optimal

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[11] United States Preventive Services Task Force. Final Recommendation Statement. Breastfeeding: Primary Care Interventions. October 2016.

[12] Bartick MC, Schwarz EB, Green BD, Jegier BJ, Reinhold AG, Colaizy TT, Bogen DL, Schaefer AJ, and Stuebe AM Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs, Maternal & Child Nutrition, Vol 13, e12366. 2016.

breastfeeding. Optimal breastfeeding was defined as 90% of infants breastfed according to medical recommendations. [13]

- Acute otitis media: Acute otitis media is a symptom of an ear infection in which there is fluid build-up and inflammation of the middle ear, usually accompanied by moderate to severe bulging eardrum. When compared to exclusive infant formula feeding, breastfeeding is estimated to reduce the risk of otitis media by 23% and exclusive breastfeeding for more than 3 months is estimated to reduce the risk by 50% for children under age 1.[14] [15] According to Bartick and colleagues, approximately 30,182 cases per a cohort of 100,000 women who will give birth during their peak childbearing years (or between ages 20-40) could be averted with optimal breastfeeding. In terms of direct medical costs, this means approximately $323 could be averted per case or approximately $517,000 per 100,000 women in a given year, adjusted to 2017 dollars. [16]

- Gastrointestinal infection: Exclusive breastfeeding for 4 months and some breastfeeding for at least 6 months is associated with a 59% reduction in nonspecific gastrointestinal infections. These conditions are usually treated without healthcare intervention or over the counter remedies, but about 9.7% require outpatient care and about 0.3% are estimated to require inpatient care. According to Bartick and colleagues, approximately 128,316 cases per 100,000 women who will give birth during their peak childbearing years, could be averted with optimal breastfeeding. In terms of medical costs covered by insurance, this means approximately $29 could be averted per case or approximately $243,000 per 100,000 women in a given year, adjusted to 2017 dollars.[17] [18]

- Lower respiratory tract infection requiring hospitalization: Exclusive breastfeeding for 4 months is associated with a 72% reduction in lower respiratory tract infections for children under age 1, when compared to exclusive infant formula feeding. Bartick and colleagues estimates approximately 1,048 cases that require hospitalization per 100,000 women, who will give birth during their peak childbearing years, could be averted with optimal breastfeeding. In terms of medical costs, this means approximately $5,600 could be averted per case or approximately $312,000 per 100,000 women in a given year, adjusted to 2017 dollars.[19] [20]

- Necrotizing enterocolitis: Necrotizing enterocolitis is a condition in premature babies where portions of the intestinal wall are infected, become inflamed, and die off. This condition affects about 1-5% of neonatal intensive care unit admissions, and about 10% of premature infants. It is rare in full term

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[13] Ibid.

[14] Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Evidence Report/Technology Assessment No. 153 (Prepared by Tufts-New England Medical Center Evidence-based Practice Center, under Contract No. 290-02-0022). AHRQ Publication No. 07-E007. Rockville, MD: Agency for Healthcare Research and Quality. April 2007.

[15] Duijts L, Jaddoe VW, Hofman A, and Moll HA. Prolonged and Exclusive Breastfeeding Reduces the Risk of Infectious Diseases in Infancy. *Pediatrics*. 2010; 126(1).

[16] Bartick et al., 2016.

[17] Ip S, et al., 2007. Duijts L, et al., 2010.

[18] Bartick et al., 2016.

[19] Ip S, et al., 2007. Duijts L, et al., 2010.

[20] Bartick et al., 2016.

babies. Premature infants fed breast milk have a reduced incidence of necrotizing enterocolitis, when compared with infants who are formula fed.[21] Bartick and colleagues estimates approximately 68 cases that require hospitalization per 100,000 women, who will give birth during their peak childbearing years, could be averted with optimal breastfeeding. In terms of costs, including professional, surgical, and medical costs, this means approximately $155,400 could be averted per case or approximately $561,000 per 100,000 women.[22] [23] [24]

If optimal breastfeeding rates were to be attained, medical costs related to these four conditions may be reduced by about $1.6 million per 100,000 women or $0.18 PMPY, in 2017 dollars. According to the most recently available estimates from the Centers for Disease Control and Prevention, about 51.8% of mothers breastfed their babies for the first six months and 22.3% breastfed their babies *exclusively* for the first six months, per medical recommendations.[25] Therefore, the estimated savings under *current* breastfeeding rates could be between $405,000 to $940,000 per 100,000 women, or $0.05 to $0.11 PMPY in 2017 dollars. These estimates are for the general population and not specifically for the California Medi-Cal population. These estimates may be different for the Medi-Cal population, given higher rates of delivery in the Medi-Cal population but lower reimbursement rates.

We have not shown our estimates of potential saving as a direct offset to the premium. Using actuarially sound methods, it is likely that no saving offset would be assumed in the premium rate development, given the small premium impact associated with this benefit. Additionally, all savings may not accrue during the premium projection period (one-year time period) because members change plans and there is evidence of "churn" in the Medi-Cal market. However, as savings develop in the underlying experience, any savings would be implicit in future premium projections, due to lower claim costs in the base period.

It is also important to note that savings estimates are limited to direct healthcare costs that are likely to be set as a result of breastfeeding. Indirect or societal benefits are not typically factored into actuarial analysis but are also important considerations.

METHODOLOGY AND ASSUMPTIONS

This actuarial analysis estimates the proportion of healthcare premiums and costs that can be attributed to breastfeeding support, supplies, and counseling services that are covered by Medi-Cal. For our analysis, we drew on data sources available through Milliman's Health Cost Guidelines (HCGs). The HCGs are a healthcare pricing tool used by actuaries in many of the major health plans in the United States. They provide a flexible but consistent basis for estimating healthcare costs for a wide variety of commercial health insurance plans. We used the Truven Health Analytics MarketScan Commercial Database to

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[21] Hunter CJ, Upperman JS, Ford HR, and Camerini V. Understanding the Susceptibility of the Premature Infant to Necrotizing Enterocolitis (NEC). *Pediatric Research.* 2008; 63; 2.

[22] Johnson TJ, Patel AL, Jegier BJ. Engstrom JL, and Meier PP. Cost of morbidities in very low birth weight infants. The Journal of Pediatrics, 2013162, 243–249 e241.

[23] Ganapathy V, Hay JW, Kim JH. Costs of necrotizing enterocolitis and cost-effectiveness of exclusively human milk-based products in feeding extremely premature infants. Breastfeed Med. 2012;7:29–37.

[24] Bartick et al., 2016.

[25] Centers for Disease Control and Prevention. Breastfeeding Report Card. United States. 2016. Available athttps://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf. .

develop utilization rates. See Appendix A for a description of the MarketScan. To estimate the proportion of Medi-Cal healthcare premiums that can be attributed to these services, we adjusted commercial utilization rates for Medi-Cal demographics and we reviewed Medi-Cal fee schedules to determine the reimbursement rates for these services.

As a first step, we worked with Ursa Consulting, CWA, and subject matter experts to define the procedures, supplies, and associated diagnoses that fall within the scope of analysis. Then, we pulled the relevant data, included claims having:

(1) Procedure codes associated with individual and group preventive counseling; office or outpatient evaluation and management services; office consultations; home visits; and self-management education and training; and diagnostic codes related to pregnancy and delivery; breastfeeding conditions; and newborn feeding conditions.
(2) Procedures codes for breastfeeding classes
(3) Procedures codes for breast pumps (manual and electronic); and hospital grade breast pumps
(4) Procedures codes for breastfeeding-related equipment and supplies

For detail code list, see Appendix B.

We summarized the utilization rates and average per-unit cost for breastfeeding support and counseling services including: individual and group preventive counseling; office or outpatient evaluation and management services; office consultations; home visits; and self-management education and training; and breastfeeding classes. We also summarized the rates and unit costs associated with breast pumps and equipment. The unit costs were trended to 2017. For the Medi-Cal population we used the Medi-Cal fee schedule rates. If Medi-Cal rates were not available in the fee schedule, we started with the commercial unit costs and reduced them to reflect the lower reimbursement in the Medi-Cal market. The utilization rates were increased to reflect the higher proportion of women of child-bearing age in Medi-Cal. Finally, we calculated the per member per year (PMPY) costs and the proportion of total average premium attributable to breastfeeding support, supplies, and counseling services.

CAVEATS AND LIMITATIONS

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman, California WIC Association, and Ursa Consulting and dated March 16, 2017. Milliman's work is prepared solely for the internal business use of Ursa Consulting and CWA. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

In performing this analysis, we relied on data and other information provided by Ursa Consultants, CWA, or their experts. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform

exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Dan Henry and Susan Pantely are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses described in this report.

The information relayed in this document are the opinions of the author and not representative of the views of Milliman, Inc. This paper should not be interpreted as an endorsement of any particular legislation or regulatory proposal by Milliman or the authors.

APPENDICES

APPENDIX A: DATA SOURCE

Truven HealthAnalytics MarketScan Commercial Database: The Truven Health Analytics MarketScan Commercial Claims Database (MarketScan) contains all paid claims generated by 15 to 50 million commercially insured lives annually depending on the year of the data. MarketScan represents the inpatient and outpatient healthcare services use of individuals nationwide who are covered by the benefit plans of large employers, health plans, government, and public organizations. The data includes diagnosis codes, procedure codes, DRG codes, and NDC codes along with the site of service information and the amounts paid by commercial insurer. MarketScan links paid claims and encounter data to detail patient information across sites and to types of providers. The annual medical database includes private sector health data from approximately 100 payers around the country. We used MarketScan data from the most recently available year, 2015.

APPENDIX B: BREASTFEEDING SUPPORT, SUPPLIES, AND COUNSELING: CODES FOR CLAIMS ANALYSIS

<table>
<tr><th>Category</th><th>Procedure Codes</th><th>Required Diagnosis Codes (ICD 9s)</th><th>Other Limitations</th></tr>
<tr>
<td rowspan="2">1. Lactation Support</td>
<td>A. Individual & Group Preventive Counseling
99401 - 99404; 99411 - 99412</td>
<td>(1) Pregnancy
ICD9: 640.00 - 677; V22 - V24.2; V27-V28.9
ICD10: O00.00 - O92.29; O94; Z34.00 - Z34.93; Z36 – Z37.9

(2) Lactation
ICD9: 676.44; 676.54; 676.84; V24.1
ICD10: O92.3 - O92.79; Z39.0-Z39.2

(3) Feeding problem in newborn
ICD9: 779.3; 779.31; 779.32; 779.33; 779.34; 783.3
ICD10: P92.1 - P92.9; R63.3

(4) Breastfeeding conditions:
ICD10: O91.03; O91.13; O91.23; O92.03; O92.13; O92.5; O92.70; O92.79; *O91.01-; *O91.11-; *O91.21-;*O92.01-; *O92.11-; O92.2; O92.29; O91.219; O91.22; ^S20.121-; ^S20.122-; B37.89; L01.00; O91.02; Q83.8; R20.3; O92.3; O92.4; O92.5; O92.6; O92.70; O92.79l; Z39.1</td>
<td rowspan="2">(i) Up to 6 visits or services</td>
</tr>
<tr>
<td>B. Office or Outpatient Evaluation & Management
99201 - 99205; 99211 - 99215</td>
<td>(1) Lactation
ICD9: 676.44; 676.54; 676.84; V24.1
ICD10: O92.3 - O92.79; Z39.0-Z39.2

(2) Feeding problem in newborn
ICD9: 779.3; 779.31; 779.32; 779.33; 779.34; 783.3
ICD10: P92.1 - P92.9; R63.3

(3) Breastfeeding conditions:
ICD10: O91.03; O91.13; O91.23; O92.03; O92.13; O92.5; O92.70; O92.79; *O91.01-; *O91.11-; *O91.21-;*O92.01-; *O92.11-; O92.2; O92.29; O91.219; O91.22; ^S20.121-; ^S20.122-; B37.89; L01.00; O91.02; Q83.8; R20.3; O92.3; O92.4; O92.5; O92.6; O92.70; O92.79l; Z39.1</td>
</tr>
</table>

Category	Procedure Codes	Required Diagnosis Codes (ICD 9s)	Other Limitations
1. Lactation Support (cont.)	A. Office Consultation 99241 - 99245 B. Home Visits 99341 - 99345; 99347 - 99350 C. Self Management Education & Training 98960	(1) Lactation ICD9: 676.44; 676.54; 676.84; V24.1 ICD10: O92.3 - O92.79; Z39.0-Z39.2	
	A. Lactation Class S9443		
2. Breast Pumps & Equipment	A. Breast Pumps (Manual & Electric) E0602 - E0603 B. Other Equipment & Supplies A4281 - A4286	(1) Post Partum Care Lactation ICD9: V24.1 ICD10: Z39.1	
	A. Breast Pump (Hospital Grade) E0604		Modifier RR**

Sources: Milliman research and analysis. The American College of Obstetricians and Gynecologists (ACOG). 2016. Breastfeeding Coding for Obstetrician–Gynecologists: Commonly Used Codes for Breastfeeding.

Notes: The codes represented in this chart with an * require a 6th digit to specify trimester. The guidelines for 6th-digit requirements for this code set are as follows: 1 (first trimester), 2 (second trimester), 3 (third trimester), or 9 (unspecified trimester). The codes represented in this chart with an ^ require an additional digit as indicated with the dash (-). The guidelines for 7th-digit requirements for this code set are as follows: A (Initial Encounter), D (Subsequent Encounter), or S (Sequela).

**RR Indicates the rental rate