

Ramping Up for Reform: Quality Breastfeeding Support in Preventive Care



A Practitioner's Guide to
Leveraging WIC and Community Partnerships

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Introduction ~ Shared Support for Breastfeeding: Building Sustainable and Effective Networks

Breastfeeding is a low-cost, low-tech preventive health strategy that can address many acute and chronic health issues for both mother and baby. As such, it is a key strategy in the health care paradigm shift to preventive services and the focus on quality of care and improved outcomes. Mothers know that breastfeeding is the healthiest way to feed their babies, but they are often faced with barriers to initiating and maintaining exclusive breastfeeding.(1) To fulfill their decision to provide breast milk for their infants, mothers need both policy and environmental support.

In California, the trend toward breastfeeding is clear: hospitals are becoming Baby Friendly and adopting policies that support mothers' decision to breastfeed,(2) and California workplaces have been required since 2002 to provide worksite lactation support.(3) Now, federal health care reform requires health plans to provide breastfeeding support as part of Clinical Preventive Services, (4) and federal law requires worksite lactation accommodation,(5) although without preempting state laws, like California's, that provide greater protection to employees.(6)

There are opportunities for communities to build safety nets to support mothers and babies in initiating and continuing to breastfeed. Historically, WIC has provided ancillary breastfeeding support, with trained staff, International Board Certified Lactation Consultants, Peer Counselors, and provision of supplies, including breast pumps. Although Medi-Cal has been the intended first point of access for breastfeeding support and supplies, reimbursement has been difficult, and providers have not been encouraged to access these benefits. However, Medi-Cal regulations have now been streamlined and simplified, providing mothers with easier access to lactation support. With health care reform, breastfeeding support will be a required benefit in health plans, including Medi-Cal, as part of the Essential Health Benefits, Clinical Preventive Services. Recent guidance from the Centers for Medicare and Medicaid Services recommends health plans provide more details to health plans providing lactation support. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf

Coordinating Care

As mothers move through their prenatal and postpartum care, from medical offices to hospitals and then to community and outpatient clinics or WIC sites, they need to be able to find staff who can assist them with breastfeeding problems and questions. It is now possible to create an integrated collaboration all along the care spectrum—from community and outpatient clinics and medical offices to hospitals and WIC clinics—that provides breastfeeding education and support with seamless referrals and communication. With such an integrated system, all health care providers know when and how mothers are receiving breastfeeding support.

This toolkit provides information and methods for providing and billing Medi-Cal for such coordination. Using it will ensure that lactation consultants are available in community and outpatient clinics and medical offices to help strengthen the network of breastfeeding support.

A pilot site of this type of referral system established in a downtown Los Angeles area selected for its complexity and challenges showed that such community collaboration



can work. A partnership established among California Hospital Medical Center, Eisner Pediatric and Family Medical Center, Public Health Foundation Enterprises WIC, Health Net, Healthcare LA Independent Physician Group, and Apria successfully deliver coordinated lactation support. By establishing a communication and referral system that responds when mothers need lactation support—including providing breast pumps and consultations—the collaboration enables mothers to access

care at all points of service. The partnership is supported by contracts, memorandums of understanding, and basic communication among all parties.

Similar partnerships can be established in any community by tapping into existing organizations, communication systems, and health plans.

Building Shared Support

Lactation consultants are urged to be active in their communities, seeking out medical offices, hospital outpatient clinics, community clinics, health plans, and WIC agencies to develop opportunities to provide services and to build shared support for lactation with community providers. WIC, as the largest employer of lactation consultants, should tap into the provisions of health care reform and work with community partners to deploy lactation consultants and find creative ways to share staff. With such partnerships in place, mothers will be provided a more effective and sustainable safety net of support.

This toolkit provides detailed information on lactation consultant qualifications, use of lactation consultants in the Comprehensive Perinatal Services Program, community clinics—particularly Federally Qualified Health Centers—and medical offices. It contains information on the provision of breast pumps through Medi-Cal and WIC, and on the issues of banked human milk as provided through Medi-Cal as well as access to some clinical services that address lactation problems. The toolkit also offers a variety of Models of Quality Care that could be adapted in local communities to ensure a shared safety net built upon community partnerships for breastfeeding support.

International Board Certified Lactation Consultants (IBCLC): Qualifications and Community Breastfeeding Support

International Board Certified Lactation Consultants (IBCLCs) are professionals who have received advanced education in breastfeeding in order to provide expert breastfeeding and lactation care, promote changes that support breastfeeding, and help reduce the risks of not breastfeeding. They are specialists who provide support in a variety of health care settings throughout the community, utilizing a variety of staffing and billing models.

IBCLCs work as members of the maternal-child health team. They know their community, assess breastfeeding mother-baby dyads, provide breastfeeding information and support, and refer mothers to other health providers and community services when necessary.

IBCLCs are utilized as part of the health care team in a variety of ways to provide breastfeeding support. IBCLCs can enhance the knowledge of the staff, assuring consistency and evidence-based practices. Once the staff in a clinic or medical office is trained in basic breastfeeding support, the IBCLC can function as a key team member for more complex breastfeeding issues. When seamless assistance is provided through staff IBCLCs, breastfeeding problems are addressed, mothers are supported to maintain breastfeeding, and exclusive breastfeeding objectives can be achieved.

Consultations for breastfeeding can take as little as a few minutes, but in many cases an hour is needed to observe, explain, and respond to a baby's body rhythms and abilities and a mother's interaction with her baby. The use of an IBCLC in a clinic or medical office frees up the time of other health professionals who would not have adequate time to spend with mother-baby dyads to provide effective lactation counseling.

Qualifications

Individuals must meet three key requirements to qualify to take an exam to become a certified lactation consultant:

- Complete higher education in the health sciences
- Complete education specifically about breastfeeding and lactation
- Provide care to breastfeeding families in a supervised clinical setting

Several pathways to certification exist to accommodate various educational and professional backgrounds. After completion of educational and clinical experience, candidates must pass an international examination, offered annually. Once an individual is board certified, he or she must recertify every five years by examination or continuing education, and all IBCLCs must recertify by examination every ten years.

Many health professionals, such as Registered Nurses, Registered Dietitians, Nurse Practitioners and Medical Doctors, are also certified as IBCLCs. However, it is not necessary to have a health background to become an IBCLC, so long as the key requirements are met and the candidate passes the exam.

Resources

Information on the authority that credentials IBCLCs, the International Board of Lactation Consultant Examiners: www.iblce.org.

Information on the professional organization of IBCLCs, the International Lactation Consultant Association: www.ilca.org.

Comprehensive Perinatal Services Program and Staffing of IBCLCs

California's Comprehensive Perinatal Services Program (CPSP) (<http://cdph.ca.gov/CPSP>) provides a wide range of culturally competent services to pregnant women, from conception through 60 days postpartum. Designed to reduce morbidity and mortality, CPSP is available to Medi-Cal-eligible mothers and their infants. The program has four goals:

- To decrease the incidence of low birth weight in infants
- To improve the outcome of every pregnancy
- To give every baby a healthy start in life
- To lower health care costs by preventing catastrophic illness in infants and children

CPSP Services include the following:

- Client orientation to comprehensive perinatal services
- Initial assessment, trimester reassessments, postpartum assessment, interventions, and follow-up services, including individual and group education in obstetrical care, nutrition, health education, and psychosocial services
- Individual case coordination
- Prenatal vitamin/mineral supplements
- Referrals to a nutrition program (WIC), genetic screening, dental care, family planning, pediatric care, domestic violence care, and more



The California Department of Public Health, Maternal, Child and Adolescent Health Division (CDPH/MCAH) develops standards and policies for the program consistent with Title 22, provides technical assistance and consultation to the local health perinatal services coordinators, and provides training for all CPSP practitioners throughout the state. Local health department staff offer technical assistance and consultation to potential and approved providers to meet the certification requirements and implementation of CPSP program standards.

Providers and Practitioners

More than 1,500 Medi-Cal providers are approved as CPSP providers, in both the fee-for-service and managed care systems. Only approved CPSP providers can bill for the enhanced CPSP services. Any of the following types of caregivers can be a CPSP provider as long as they are an active Medi-Cal provider, have an active National Provider Identifier (NPI) number, and are in good standing with their licensure board:

- Physician (obstetrician/gynecologist, family practitioner, general practitioner, or pediatrician)
- Medical Group, any of whom is an obstetrician/gynecologist, family practitioner, general practitioner, or pediatrician
- Certified Nurse Midwife
- Nurse Practitioner (family or pediatric)
- Preferred Provider Organization (PPO)
- Clinic (hospital, community, county)
- Alternative Birth Center

Providers complete an application process that is reviewed by the County Perinatal Services Coordinator and state staff at the MCAH Division. Once approved, the provider has a billing modifier added to their Medi-Cal billing number for CPSP billing. The CPSP provider site employs or contracts with a variety of health practitioners for the support services in CPSP programs, including any of the following practitioners to deliver services appropriate to their skill level:

- Physicians (general practice, family practice, OB/GYN, pediatrician)
- Certified Nurse Midwives
- Nurse Practitioners
- Public Health Nurses
- Physician's Assistants
- Registered Nurses
- Licensed Vocational Nurses
- Social Workers
- Psychologists
- Marriage, Family, and Child Counselors
- Registered Dietitians
- Health Educators
- Certified Childbirth Educators (Lamaze, Bradley, ICEA)
- Comprehensive Perinatal Health Workers

The CPSP provider is required to have appropriate staff for the risk level of patients, and there is some flexibility in staffing the program to meet the psychosocial, nutrition, and health education requirements. For example, a qualified practitioner other than a social worker could provide psychosocial support. Registered Dietitians are not required for nutrition education. And health education can be provided by a number of qualified staff.

Although a CPSP provider may employ or develop professional relationships with other practitioners for delivery of services, ultimately the CPSP provider is responsible for the client's care.

An International Board Certified Lactation Consultant (IBCLC) may provide group and individual education to clients per their Scope of Practice (www.iblce.org/upload/downloads/ScopeOfPractice.pdf).

Models of CPSP Service Delivery

CPSP programs can be located in solo and group practices, health departments, hospitals, community clinics, managed care plans, Federally Qualified Health Centers, Indian Health Services, Rural Health Clinics, and residency programs. Usually, both obstetric and support services are provided in one location. However, it is possible to have obstetric services in one location and support services subcontracted in another location or from another CPSP provider. This flexibility allows for use of a variety of professional and paraprofessional practitioners.

Staffing IBCLCs in CPSP Programs

Breastfeeding and early infant feeding are major areas of prenatal education and postpartum support. Having all CPSP staff trained in basic breastfeeding education and also staffing highly trained IBCLCs will ensure better quality of care, increased breastfeeding rates, improved health outcomes, and better case management.

During their pregnancy, women have numerous questions about breastfeeding, and individual women may have individual concerns that need to be addressed in order to successfully initiate breastfeeding. Once their baby is born, many mothers face normal breastfeeding challenges in the first few days, weeks and months. Having established a relationship with an IBCLC on staff in her CPSP program ensures that a woman is able to receive assistance in a timely manner with a trained professional to overcome breastfeeding challenges, maintain exclusive breastfeeding and continue to breastfeed as long as she desires.

Although IBCLCs are not identified specifically on the CPSP list of support practitioners, they are listed in the 2010 Provider's Handbook, with examples of some of the services they can provide within a CPSP program (<http://www.cdph.ca.gov/programs/CPSP/Documents/MO-CPSP-ProviderHandbook.pdf>). One way they can be included is to have a practitioner such as a Nurse Practitioner, Registered Nurse, or Registered

Dietitian also be certified as an IBCLC. However, it would be important for that staff person to have dedicated time for breastfeeding support and not be primarily responsible for other types of clinical care.

An IBCLC can also be hired as a Comprehensive Perinatal Health Worker (CPHW). A CPHW must be eighteen years of age, a high school graduate, and have had one year of paid perinatal experience. Many IBCLCs who might not fit the educational background of the other practitioners would be able to fulfill these requirements. A CPHW could provide appropriate nutrition, health education and psychosocial interventions, beginning with a comprehensive initial assessment to identify strengths and risk conditions. As the complexity of conditions increases, the level of expertise required to provide the client with the appropriate assessment, education and counseling must also be greater. CPHWs and other staff should have access to discipline specialists to ensure appropriate interventions for complex or high-risk conditions.

An IBCLC hired as an IBCLC but listed on the CPSP practitioner list as a CPHW makes the time they spend with eligible clients billable within Medi-Cal.

An IBCLC could also provide support to several CPSP programs. If licensed, such as a LVN, RN, or Nurse Practitioner, an IBCLC can bill Medi-Cal for home visits.

Billing for Lactation as a CPSP Service

There are many opportunities for an IBCLC and the CPSP staff to bill for breastfeeding services. Under the psychosocial, nutrition, and health education requirements, women are seen for initial assessments, trimester reassessments, postpartum assessments, intervention, and follow-up, in group or one-to one visits.

Below are details for understanding the reimbursement for obstetric and support services, bonuses, and billing codes.

Reimbursement for obstetric services:

Initial exam before 16 weeks LMP (includes bonus of \$56.63 for early initial exam)	\$182.94
Initial exam after 16 weeks LMP	\$126.31
Tenth antepartum visit (one only)	\$113.26
Delivery (vaginal or cesarean)	\$544.72
Postpartum exam (one only)	\$60.48

Reimbursement for support services:

Both individual and group visits are billable as shown in Table 1, below, with these rules:

- The rate is the same statewide, unless service is provided in a Federally Qualified Health Center or Rural Health Center, or the medical provider is providing services as fee-for-service, where the rate schedule differs. The rate applies to all practitioners, including non-licensed staff.
- Billing is in 15-minute increments.
- Contact must be face-to-face.
- A referral from a medical doctor is not required to see a mother.
- There is a maximum time allowed for CPSP services: 23 hours for individual support services and 27 hours for group support services.
- Treatment Authorization Requests (TAR) are available for additional support services, if needed, but are not required for obstetric services.
- Support services, such as nutrition education, do not have to be provided on the same day as an obstetric visit.
- Home visits are allowed for CPSP services, but only by licensed practitioners (LVN, RN, LCSW).

Table 1. Billing Rates for Individual and Group Support Services

<i>Time for Visit</i>	<i>Units</i>	<i>Individual</i>	<i>Group (per patient)</i>
0-7 minutes	0	Not billable	Not billable
8-22 minutes	1	\$8.41	\$2.81
23-37 minutes	2	\$16.82	\$5.62
38-52 minutes	3	\$25.23	\$8.43
53-67 minutes	4	\$33.64	\$11.24

Billing codes for CPSP support services, as shown in Table 2, include services for initial assessment and care plan, follow-up for both individual and group visits, and postpartum assessment.

Table 2. Billing Codes for CPSP Support Services

<i>Service</i>	<i>Billing Code</i>
Patient Orientation	Z6400
Initial Support Services Assessments and Care Plan	Z6500
Nutrition Services	Z6200, Z6202, Z6204, Z6208
Psychosocial Services	Z6300, Z6302, Z6302, Z6304, Z6306, Z6308
Health Education	Z6400, Z6402, Z6404, Z6406, Z6408
Perinatal Education	Z6410, Z6412, Z6414

Staff Training and Billing Services

Staff should be trained to bill accurately for services provided, especially with drop-in visits or when unscheduled services are provided. For example, the time spent with a postpartum breastfeeding mother who stops by the clinic to speak with the IBCLC or clinic staff about sore nipples or breastfeeding questions can be billed as a health education visit.

See Appendix 1 for billing codes and reimbursement for nutrition, psychosocial, and health education in CPSP.

See Appendix 2 for a sample billing form for group education.

For more information: www.cdph.ca.gov/programs/cpsp.

Lactation Consultant Services in Federally Qualified Health Centers

Opportunity and need exist for community clinics, which are the “safety net” providers in both urban and rural communities, to provide the services of lactation consultants. There are several types of community clinics, many of which are defined as Federally Qualified Health Centers (FQHC), including Community Health Centers, Public Housing Primary Care Centers, Migrant Health Centers, Indian Health Services Clinics, Rural Health Services Clinics and Health Care for the Homeless Programs.

Reimbursement for Lactation Consultation

The designation of FQHC is a reimbursement designation for funding. These clinics receive a rate of compensation that is calculated for each individual clinic, based partially on the services provided. The rate of compensation can be recalculated on an annual basis. In California this rate varies between \$100 and \$300 per day.

An important factor for an FQHC is that there are no limits to the number of times a patient can be seen. This feature is very helpful in providing breastfeeding support, as breastfeeding problems can change on a daily and weekly basis in the first few months, and some situations can be very complex, with breastfeeding dyads requiring frequent and close follow-up.

There are some restrictions on when billing can occur for lactation support at an FQHC:

- Instruction on a breast pump can only be charged if it’s on a day separate from the day of hospital discharge.
- A mother must be present for the clinic to be able to bill for instruction on pump use.
- If a mother sees a physician and lactation consultant on the same day, the visit can be charged for the daily rate only once.
- If a mother has a dental visit and a perinatal care visit on the same day, each visit can be charged the daily rate.
- Separate charges can be submitted if the baby and mother have visits on the same day, as they are different patients.
- No prior authorization is required for a mother to be seen in her FQHC clinic for breastfeeding support.
- A Treatment Authorization Request (TAR) is not required to provide a consultation.

Lactation Consultations

IBCLCs working in FQHC clinics assisting mothers and their babies to overcome barriers to breastfeeding can provide timely early interventions that could reduce subsequent health care costs for both mothers and babies. An IBCLC can also educate her co-workers, increasing the availability of optimal maternity and pediatric practices during the critical early postpartum period. Collaboration with WIC would assure that if an appointment at WIC was missed, staff at the community clinic could provide the needed care.

In January 2006, Medi-Cal regulations changed to allow mid-level practitioners such as Registered Dietitians and Health Educators to be reimbursed at the substantially higher FQHC rate. IBCLCs who are not otherwise licensed as a Registered Nurse or Nurse Practitioner can work with other licensed practitioners in the FQHC to provide services. As long as the licensed practitioner has at least eight minutes of face-to-face time with patients, the daily encounter rate would apply.

For example: A mother and baby needing help with breastfeeding are seen by the IBCLC, who may spend from 30 to 60 minutes answering questions and addressing problems. The IBCLC then has the licensed provider join them in the consultation, and the mother, IBCLC, and provider review the lactation evaluation and the plan and follow-up together. The provider can then bill for the encounter.

Thus, the valuable services of the IBCLC provide income to the clinic and help fund her position. She is also an important link in the community safety net for mothers needing lactation support. In addition, she increases the skill level of the providers in the agency so that patients receive appropriate care even when she is not available.



Best Practices

IBCLCs should work with all members of the health care team, providing training in basic breastfeeding promotion and support to all who work in primary care, obstetrics, and pediatrics. An initial 16-20 hour training, for example, scheduled to accommodate the clinic staff, could be followed by opportunities to observe clinical interactions. Ongoing in-services should be scheduled to assure consistent evidence-based practices are maintained. The IBCLC should also develop relationships with all staff, so they trust the IBCLC's expertise and view that person as a valuable asset to the clinic team, vital for quality of care and high breastfeeding rates.

The IBCLC should also develop strong relationships with other community providers, including WIC and hospital staff. Together, they should work out referral and communication systems for exchanging information about mothers for prenatal and postpartum care.

In addition, the agency should assist the IBCLC in meeting the requirements of continuing education units to renew certification and to assure the IBCLC is aware of changes in practice that must be shared with co-workers and community partners.

Lactation Consultant Services in Medical Offices and Hospital Outpatient Clinics and for Health Plans

A breastfeeding safety net requires the participation of IBCLCs who provide breastfeeding education and support to patients and staff in medical offices and hospital outpatient clinics, as well as those funded through health plans.

Medical Offices

Working with medical practices, lactation consultants can negotiate to provide



services either through a Memorandum of Understanding (MOU) or a contract. Generally, the medical providers then refer patients to the lactation consultant, using a preferred provider listing of local IBCLCs. The IBCLC visits the mother in the home, or the mother is seen by the IBCLC in the medical provider's office. The IBCLC bills for services using agreed-upon rates and a specified number of authorized visits. The IBCLC does not need to be licensed in this situation.

IBCLCs should approach local medical provider offices, set up a meeting to

discuss services, and present a proposal to provide services.

Hospital Outpatient Clinics

In a hospital outpatient office IBCLCs can see mothers either by appointment or on a drop-in basis. Most examples of breastfeeding support in this setting have used Registered Nurses who are also IBCLCs. Sometimes this support service is co-housed with a small store for breastfeeding supplies, run by the hospital.

If the IBCLC is not a nurse, some hospitals have included her services as part of the nutrition budget rather than the nursing budget.

The IBCLC bills the Medi-Cal or commercial health plan for her breastfeeding support services. Referrals can be made by the medical providers with privileges at the hospital or in the local area. Mothers can also self-refer and then submit the claim to their insurance or pay cash. With the Affordable Health Care Act, all health plans, including commercial health plans, should cover visits to a lactation consultant. How the referral process will work is yet to be developed and may be specific to each plan.

Health Plans

Health Plans should be encouraged to improve their breastfeeding support and develop model breastfeeding benefits in anticipation of the need to meet the requirements of the Affordable Care Act. Under the Act breastfeeding support is required as part of Clinical Preventive Services (<http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>).

Lactation consultants, working with peers and their local breastfeeding coalition, should schedule meetings and presentations with health plan representatives, including commercial and government-supported plans. Key health plan staff to include in meetings are Medical Officers and management staff from Member Benefits and Utilization Management.

Health plans should publish lists of IBCLCs who have been approved to provide services to their members as preferred providers so that medical providers can easily access this list and find assistance for their patients in a timely manner. Examples of companies already providing referrals to IBCLCs include Health Net (www.healthnet.com) and Central California Alliance for Health (www.ccah-alliance.org/healthtips.html). Due to its size, California will have a variety of commercial health plans, as well as the California Health Benefit Exchange and Medi-Cal, but all health plans will be required to provide breastfeeding support.

The billing process is determined by the health plan and medical providers. In some cases, the lactation consultant would bill the medical providers directly, by agreement with the health plan. In other cases, the lactation consultant would bill the health plan.

Resources

To locate Medi-Cal Managed Care Plans in each county, go to www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

Information for the California Health Benefits Exchange can be found at www.healthexchange.ca.gov/Pages/Default.aspx

See the next section on Billing Codes for information on billing.

Lactation Billing Codes

Medi-Cal includes lactation evaluation and management as a benefit and provides the following information on billing codes:

Providers eligible to bill CPT-4 codes 99201–99205 (office or other outpatient visit for the evaluation and management of a new patient) and 99211–99215 (office or other outpatient visit for the evaluation and management of an established patient) may bill for medically necessary services related to non-routine problems associated with breastfeeding using the infant’s Medi-Cal ID number. The infant must be present at the time the service is rendered.

The ICD-9-CM diagnosis code on the claim should be a specific diagnosis of the infant. An example would be ICD-9-CM code 750.0 (tongue tie). Providers are reminded that, of the CPT-4 codes listed above, only 99211 (office or other outpatient visit for the evaluation and management of an established patient [may not require the presence of a physician]) should be billed if the service is not rendered by a physician or a non-physician medical practitioner. (The term “non-physician medical practitioner” includes a Physician Assistant, a Nurse Practitioner or a Certified Nurse Midwife.)

Many additional ICD-9 billing codes are available for lactation consultants and medical providers to address the problems for either the baby or mother for lactation.

Resources

http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_10133.asp

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval_m00o03.doc

The Medi-Cal Learning Portal provides Medi-Cal learning tools about claims, eligibility, electronic Treatment Authorization Requests (eTARs), and more. The site also lists the Regional Representatives who can assist with billing. <http://learn.medi-cal.ca.gov>.

See Appendix 3, The Primary Care Pediatrician’s Guide to Getting Paid. Also available at <https://www2.aap.org/breastfeeding/files/pdf/CODING.pdf>

See Appendix 4, Health Insurance Claim Form 1500, for a sample commonly used billing form.

Provision of Breast Pumps and Supplies

Breast pumps should be used judiciously to help mothers initiate or maintain breastfeeding when faced with breastfeeding problems or for a situation where mother and baby are separated, such as for work or school. The goal should always be to promote and maintain as much feeding at the breast as possible, with breast pumps serving as a support tool.

Breast pumps and supplies are a Medi-Cal benefit, provided to mothers through their health plans for medical necessity.

Breast pumps are considered Durable Medical Equipment for billing purposes. Medi-Cal covers Durable Medical Equipment (DME) when provided on the written prescription of a licensed provider within the scope of his/her practice. The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed DME items may be covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability. For more on durable medical equipment, see <http://tinyurl.com/6cw4t4l>.

Durable Medical Equipment is provided through a DME Provider. DME providers deliver their goods in a variety of ways. Some have brick-and-mortar storefronts where a mother can take a prescription for a breast pump, other companies deliver equipment and breast pumps to the home, and some providers drop ship certain equipment to a mother's home, including breast pumps. There is no requirement that a DME provider instruct a mother in the use of a breast pump.

Durable Medical Equipment

Durable medical equipment is equipment prescribed by a licensed practitioner to aid in a better quality of life. Durable medical equipment is equipment that:

- Can withstand repeated use
- Is used to serve a medical purpose
- Is not useful to an individual in the absence of illness, injury, functional impairment, or congenital anomaly
- Is appropriate for use in or out of the patient's home.

Cal. Code, Reg. Title 22 § 51160: accessed 12/12/11 from www.archive.org/stream/ca.ccr.22.2#page/n223/mode/1up

Becoming a DME Provider for Lactation

The Department of Health Care Services approves applications for new durable medical equipment providers. Although a moratorium exists in some counties for new providers, applications can be submitted in any county for new lactation specific DME providers. Certain requirements must be fulfilled that are necessary for all DME providers, so a review of the application process is advised. A few lactation specialists have taken advantage of this opportunity and are in the application process.

For more information

Information on the moratorium exemption for lactation: http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/PED_DME_Moratorium_Declaration.pdf

Information on the DME application process: <http://www.dhcs.ca.gov/provgovpart/Pages/DurableMedicalEquipmentApplicationPackage.aspx>

Types of Breast Pumps

There are two kinds of breast pumps. Hospital-grade, multi-user pumps are used to establish milk supply and are the preferred pump to use while solving most breastfeeding problems. Personal, single-user pumps are used to maintain milk supply, once established.

Hospital-grade pumps are defined by the Food and Drug Administration. They are built and engineered for multiple use as provided by a DME provider, pump rental station, or on loan from WIC. These pumps can be used by many mothers, who are provided their own pump kit, including tubing to connect from pump to breast, flange to attach to breast, and collection bottles.

Personal, single-user pumps are not meant to be used by more than one person, as they are not engineered to prevent the potential spread of viruses, and their motors are not designed to be used 8 to 12 times daily for many weeks and months. They are purchased for individual use and come with a pump kit.

Double pumping, where both breasts are pumped simultaneously, can help a mother initiate and maintain her milk supply. In many cases mothers would be better served if they could obtain two breast pump kits. If using the personal-use pump, which comes with a kit only for single pumping, the mother can check at her WIC clinic for the availability of a second kit or request a second kit, billed to Medi-Cal, the next month. If using the hospital-grade pump, purchasing two kits at the same time would not be a problem.

Medi-Cal has always been designated the first provider of breast pumps and breastfeeding supplies when the mother-baby dyad exhibited difficulty in breastfeeding. However, over the last decade, with the expansion of breastfeeding support in WIC, challenges of accessing breast pumps, and the difficulties that the

limited number of DME providers experienced in obtaining reimbursement through Medi-Cal, WIC has provided the majority of breast pumps. With recent improvements in Medi-Cal regulations and more clear policies and procedures, and with the Clinical Preventive Services requirement for breastfeeding in the Affordable Care Act, Medi-Cal and WIC will now share responsibility for providing breast pumps and supplies.

Billing for Breast Pumps

The January 2012 Medi-Cal Bulletin, Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates, page 32 (Word file duracd_a04a08a08p00.doc downloadable at <http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/dme201201.asp#a10>) provides the following information on breast pump billing codes and reimbursement rates (Table 3).

Table 3. Breast Pump Billing Codes and Reimbursement Amounts

HCPCS Code	Description	Reimbursement
E0602	Breast pump, Manual, any type or breast pump kit.	\$23.62
E0603	Breast pump, electric (AC and/or DC), any type. This is also known as a personal grade (single-user) electric breast pump.	\$93.15
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type. This is also known as a hospital grade (multi-user) electric breast pump.	\$2.72/daily rental

Hospital Multi-User Breast Pumps

A Treatment Authorization Request (TAR) is required to acquire a hospital-grade, multi-user breast pump, but not for a personal, single-user pump. The following information providing clarification regarding the Treatment Authorization Request (TAR) documentation requirements for HCPCS code E0604 is from the Medi-Cal Update, Durable Medical Equipment and Medical Supplies, January 2012, Bulletin 436 (<http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/dme201201.asp - a10>). That bulletin links to the document, Durable Medical Equipment (DME): Bill for DME (word file drabildme_a04p00), which on page 19, details specific situations regarding the need for a TAR for hospital-grade pumps, reproduced below. It is important to note that previous use of a personal-use pump is not required in order to obtain a hospital-grade pump.

A TAR must be accompanied by documentation establishing that the item is medically necessary in either of the two following situations:

1. If direct nursing at the breast *is* established during the neonatal period (the period immediately following birth and continuing through the first 28 days of life) and nursing is interrupted, medical necessity for code E0604 is defined as the existence of any of the following medical conditions:
 - The mother has a medical condition that requires treatment of her breast milk before infant feeding; or
 - The mother is receiving chemotherapy or other therapy with pharmaceutical agents that render her breast milk unsuitable for infant feeding; or
 - The infant developed a medical condition or requires hospitalization that precludes direct nursing at the breast on a regular basis.
2. If direct nursing at the breast is *not* established during the neonatal period, medical necessity for code E0604 is defined as the existence of any of the following medical conditions:
 - Any maternal medical condition that precludes direct nursing at the breast; or
 - The infant has a congenital or acquired neuromotor or oral dysfunction that precludes effective direct nursing at the breast; or
 - The infant has a congenital or acquired condition that precludes effective direct nursing at the breast; or
 - The infant continues to be hospitalized and the mother is no longer an inpatient.

There are guidelines describing when a TAR is required for a hospital-grade pump as well as exceptions to those guidelines. In most cases a TAR is required when the costs of DME equipment reach \$50 within a 15-month period. For a hospital-grade

Due to an exception in DME requirements for breast pumps, a TAR is not required until the cost reaches \$164 or 60 days.

pump that rents at \$2.72/day a TAR would be required within 18 days. This

requirement could pose a problem at a critical time in a baby's life, when a mother is trying to establish her milk supply in the early weeks, especially if her baby remains in the hospital neonatal intensive care unit. TAR procedures might lead to her losing access to her breast pump, which could compromise her baby's access to her milk as well as her ability to establish adequate milk production. However, thanks to WIC data demonstrating that most mothers return a hospital-grade pump within two or three months, an exception to the TAR process has been made by the Department of Health Care Services. The exception states that a TAR is not required for a hospital-grade pump until the cost reaches \$164, or 60 days.

Personal/Single-User Breast Pumps

Personal-use pumps are appropriate for mothers who have established their milk supply and are using a pump for an ongoing breastfeeding problem, or due to separation for medical reasons or for work or school.

There is a large variety of personal-use pumps. Those of high quality are effective for supporting breastfeeding, but many are not appropriate and are ineffective in supporting breastfeeding. Mothers should be advised and supported in using quality pumps in order to maintain their breastfeeding efforts.

For accessing breast pumps through Medi-Cal, unlike for hospital-grade pumps, there are no equipment specifications for the personal-use pumps that DME providers are required to provide. To maximize their return, DME providers could provide a lower-priced and lower-quality breast pump, which would not support breast milk supply.

Work started in the 1990s to include equipment specifications for personal-use pumps in the Manual of Criteria (MOC) for Medi-Cal provided products. However, the MOC is no longer used by the Department of Health Care Services, and there is no precedent for detailed descriptions of equipment related to billing codes. Breastfeeding advocates and breast pump manufacturers developed a set of equipment specifications for personal-use pumps that would guide DME providers and breast pump manufacturers in providing quality personal-use pumps that will support continued breastfeeding.



See Appendix 5, Personal Single-User Breast Pump Quality Equipment Specifications.

In the last few years, the major breast pump manufacturers have produced personal pumps for DME providers that contain quality pumping equipment at a reduced wholesale price, providing DME providers with a reasonable return on their investment and mothers pumps of a quality that should support an established milk supply. Breast pump manufacturers have also made available easy-to-use prescription pads for

medical providers for ordering breast pumps through DME providers. The pads include diagnosis codes and check-offs for equipment needed.

Best Practices for Using Breast Pumps

With breast pumps available through Medi-Cal and given the ease of ordering a pump with pre-printed prescription pads, there is a risk of health care providers substituting milk pumping rather than supporting breastfeeding. A pump is meant to be a tool to promote exclusive breastfeeding, with emphasis on feeding at the breast as much as possible. Although it is important to utilize breast pumps as a means to feed the baby while breastfeeding issues are addressed, vigilance should be maintained to encourage and support feeding at the breast. The goal is to facilitate access to breast pumps and feeding supplies while avoiding the overprescribing and misuse of breast pumps.

Health providers in each community must have good referral systems and open lines of communication when mothers are in need of breastfeeding support, especially when a breast pump is required, in order to protect and support breastfeeding. The following best practices should be in place:

- Those providing medical care to mother and baby as well as agencies that provide them with support (WIC, Public Health Nursing, and so on) should develop a system that allows for communication among them. In that way, when a mother has been referred for a breast pump, she will also receive breastfeeding support, instruction in the correct and effective use of the breast pump, and access to those who can help her work toward overcoming her breastfeeding problems, maintain her milk supply, and end up breastfeeding at the breast whenever possible.
- Referral and prescription materials for breast pumps should always include a check-off for a referral to a lactation consultant in a clinic, medical office and WIC. Mothers should not receive breast pumps without breastfeeding support.

Benefits of Breastfeeding at the Breast

- Hormones are released by both mother and baby that help in bonding as well as milk production.
- Milk delivered to the baby changes from low- to high-calorie food, helping to trigger satiation.
- The infant is in control of ending the feeding, as the mother is not able to measure amounts, thereby allowing for a variety of intake based on need rather than schedules.
- The infant exposes the mother to any microbes it has been exposed to, leading to the efficient development of antibodies and their delivery to the baby.
- Infant oral development is enhanced.

Medi-Cal Coverage for Frenotomy

Medi-Cal provides reimbursement for frenotomies, or clipping of the frenulum under the tongue, to correct ankyloglossia, or “tongue tie,” in order to allow the baby to breastfeed properly.

The following information is provided in the Medi-Cal Update-Billing and Policy, December 2007 (Bulletin 402):

- Effective for dates of service on or after January 1, 2008, incision of lingual frenum (frenotomy), CPT-4 code 41010, is a Medi-Cal benefit. This service:
 - Does not require a Treatment Authorization Request
 - Is reimbursable only for recipients younger than 1 year of age
 - Is a once-in-a-lifetime procedure
 - Is reimbursable for primary surgeon services only (assistant surgeon services are not payable)
 - Is not reimbursable to non-physician medical practitioners (NMPs)
 - Is reimbursed at \$153.02

Medi-Cal Coverage for Banked Human Milk

Banked human milk is provided by Medi-Cal and health insurance plans in order to provide infants, especially high-risk infants, the healthiest start in life and reduce costly health complications. Donor milk offers all of the benefits of human milk for the infant or child, including optimal nutrition, easy digestibility, and growth factors to promote maturation and healing of tissues, immunologic protection, and infection-fighting components. For some children, banked human milk is the only source of nutrition that allows them to grow and develop without allergic symptoms. In the past 37 years, there has never been a documented disease or illness transmission through processed human milk.

Processed human milk is dispensed only by physician prescription or by hospital purchase order. The prescription must include the following:

Processed human milk _____ ounces/per day for _____ weeks/months/year

An outpatient prescription must include the parent/guardian's name and phone number along with a diagnosis. The prescription can be faxed to (408) 297-9208, but the original must be mailed to the milk bank:

Mothers' Milk Bank
Valley Medical Center
751 S. Bascom Avenue
San Jose, CA 95128

If the infant requires an increase in supply, a new prescription is needed.

For outpatient infants, the first shipment is usually for one week of milk. If the family can hold more milk in their freezer, a monthly supply will be shipped, when available.

When the hospital orders the milk, a purchase order number is required, along with mother's address, attending physician, and whether the order is for premature milk or mature milk. The hospital can provide a verbal order and then fax a written doctor's order to (408) 297-9208.

See Appendix 6, Hospital Request for Milk Form.

For some NICU units in California, the physician may want to have a supply of processed donor milk stored in the freezer at all times. Other hospitals order donor milk when a patient needs it. The processed milk has a six-month expiration period.

There is a processing fee charged to cover the expenses of milk bank operations. Transport fee is charged separately.

Billing for Banked Human Milk

- The milk bank charges \$3.00/oz for inpatient and outpatient.
- If the hospital requests a smaller sized bottle, then it is \$4.00/oz.
- Reimbursement for Medi-Cal is 10% less than \$3.00/oz.; the milk bank covers the transport costs for Medi-Cal patients.
- There is not a billing code (CPT code) for third-party insurers or Medi-Cal for billing for donor milk by health professionals, agencies, or families.
- For outpatient Medi-Cal recipients, the Milk Bank bills Medi-Cal for the processing of human milk for the client (HCPC code T2101). No one else can bill Medi-Cal for this code.
- For inpatient recipients, the hospital pays the milk bank for the service and then bills the recipient.
- Private pay families usually pay for the milk and then seek reimbursement from their insurer for the supply of milk and shipping.

Breastfeeding advocates and health professionals are encouraged to reach out to health insurance plans and urge inclusion of banked human milk for infants.

More information can be obtained by emailing Bank/MothersMilkBank@hhs.co.santa-clara.ca.us or contacting the milk bank at (408) 998-4550/fax:(408) 297-9208.

Models of Community Breastfeeding Support

A variety of models for staffing IBCLCs in hospitals, clinics, medical offices, WIC clinics, and through health plans are possible, and several are currently in use. This section provides case studies for staffing IBCLCs for consultation and billing for services.

On-site IBCLC Staffing

Communicare Health Center, Yolo County (www.communicarehc.org)

Communicare Health Center is a Federally Qualified Health Center offering a variety of services, including comprehensive primary medical and dental care at five community clinic locations. For three years, an IBCLC has provided services for patients.

This program has been successful thanks to the thoughtful and strategic use of the expertise of the lactation consultant. She provides 16 hours of basic breastfeeding training to pediatric, obstetric, and family practice staff, offering them a basic understanding of and skills to promote breastfeeding and assist with misinformation and simple problems. The lactation consultant is available to all staff to provide breastfeeding support and education. Periodic informal in-service updates are provided during staff meetings. Most important, the training and relationship building between the lactation consultant and medical staff have resulted in the staff referring complex breastfeeding issues to the consultant that might not have been addressed.

The lactation consultant sees mothers in the CPSP program and bills for the daily rate calculated for Communicare as an FQHC, rather than the lower CPSP rate. Because her educational background is not one of the approved CPSP professions, she is considered a Comprehensive Perinatal Health Worker.

For mothers not in the CPSP program, visits with the IBCLC are billed at the FQHC rate, as she supports the medical staff. The lactation consultant will see a patient as a collaborative appointment in conjunction with a medical provider. The lactation consultant documents her assessment and plan on the progress note, at which point the medical provider consults face-to-face with the lactation consultant and the patient in the office. The medical provider completes the progress note and bills for the exam under a regular office visit billing code.

Communicare and Yolo County WIC also work closely to provide referrals and monitor support for mothers. These efforts are key to the safety net that mothers need to initiate and maintain breastfeeding.

This model has the following strengths:

- The clinic staff work as a team to provide high-quality services.
- The lactation consultant saves the clinic staff time by working with complex breastfeeding issues.

- The lactation consultant has proven to the medical staff the value of the services of an IBCLC.
- The lactation consultant increases the medical staff's skills and knowledge of breastfeeding support; the staff can help mothers when the consultant is not available.
- The consultant provides collaboration between the community clinic and WIC for referrals and support.

Referral to Breastfeeding Support with Payment by Health Plan

Central California Alliance for Health (www.ccah-alliance.org)

Central California Alliance for Health (CCAH) is a health plan serving Merced, Monterey, and Santa Cruz counties. CCAH long ago recognized the value of breastfeeding, and plan members have been receiving breastfeeding support for some years.

Members are provided access to IBCLCs, home-visiting nurses, and hospital-grade and personal pumps and lactation supplies. The Alliance maintains a list of pre-approved lactation consultants who are reimbursed for their services for assisting CCAH members. Mothers may self-refer or be referred by a physician, mid-level provider, certified nurse midwife, or Alliance case management staff.

The lactation consultant can provide services at any location, including her office, the patient's home, or from a desk in a provider's office, such as at a WIC site, to provide services to CCAH members. Home visiting nurses also visit mothers postpartum, especially mothers who have never breastfed or were previously unable to breastfeed for longer than one month.

IBCLCs do not need to have a Medi-Cal provider number to provide services. They are reimbursed at \$25 per 30 minutes, and visits are limited to two 30-minute units per visit. Claim forms CMS 1500 (see Appendix 4) or UB04, available at office supply stores, are required for billing. For consultations, no TAR is required for four units per 12-month period, for a total of two hours.

CCAH also provides breast pumps through contracted pharmacies, medical supply vendors, or approved IBCLCs. Personal-use pumps are provided to mothers for medical reasons or for return to work or school. The pump can be ordered by a physician, mid-level provider, certified nurse midwife, or Alliance case management staff. No Referral Authorization is required. The Alliance reimburses supplies at 80% of manufacturer's suggested retail price (MSRP), up to \$246.00. TARs are required only if a hospital-grade pump is required for longer than 60 days.

This model has the following strengths:

- Efficient use of allied health professionals—IBCLCs.
- Flexibility in where and how mothers are seen.
- Ease of billing for IBCLC.

On-site Support Linked Between Clinic and WIC

North County Health Services (NCHS), San Diego County (www.nchs.org)

This full-service FQHC is also a CPSP provider. This clinic model, still in the process of development, bills for both nutrition and lactation support services at the higher FQHC rate, rather than the CPSP rate.

Registered Dietitians provide the prenatal nutrition education for CPSP patients. The goal is for the RDs to see the moms three times during the course of the pregnancy, ideally once during each trimester. Staff in Women Health Services (WHS), NCHS's obstetric program, provide other pieces of the CPSP services, including psychosocial and health education. In the two Sweet Success WHS clinics, Registered Dietitians who are also Certified Diabetes Educators work with the moms with gestational diabetes, seeing them at a much higher frequency, sometimes weekly.

Once the baby is born, mothers are seen for feeding/lactation assistance and maternal nutrition over the course of the six- to eight-week postpartum period. Again, there is a goal of three visits per mother in the postpartum period:

- The first visit is for Newborn Feeding Assistance: This is ideally performed at three to seven days of age, when the infant comes in to see the pediatrician for the first time. Mother and baby are seen for feeding assistance by an IBCLC or Lactation Educator staff member who is a Registered Dietitian or Degreed Nutritionist. The information from the visit is communicated to the physician. If there are any problems, normal standard of care is for mother and baby to return for a follow-up visit in a few days.
- The second visit is scheduled for one to two weeks postpartum. In addition to checking on how the infant feeding is going, the Registered Dietitian assesses the mother's eating, drinking, and resting, and probes for any other concerns.
- The third visit is scheduled for four to six weeks postpartum. This is a full visit with a Registered Dietitian for postpartum nutrition assistance.

In addition to these visits, efforts are being made to integrate clinic staff work with WIC work so that each visit builds on nutrition information already provided in either setting. A "Nutrition Fast Pass" was developed as a way to share what happened in the clinic with WIC. Mothers carry a Fast Pass to their WIC visit. This collaboration makes for more efficient provision of services and better use of staff in the clinic and WIC.

NCHS is now getting Electronic Health Records (EHR) and since 60% or more of the WIC families are patients of NCHS, WIC families are being asked to sign a consent form allowing NCHS to share the "Nutrition" part of their electronic health record with WIC, as needed.

The WIC and NCHS network is now “married,” so that a Registered Dietitian working in WHS-OB can access the WIC database and vice-versa. Although the networks are completely separate, it is possible to access the data of both, increasing efficiency and timeliness of care. In one of the NCHS Sweet Success clinics, a Registered Dietitian is able to provide WIC checks for mothers who come in for their CPSP nutrition appointment. Mothers can either opt for the vouchers to be mailed or pick them up at the clinic (just down the street) that day. The “WIC” paperwork is inter-officed to the site from which the checks were issued.

This model has the following strengths:

- Comprehensive care for nutrition and breastfeeding between WIC and community clinic services.
- Efficient use of RDs and IBCLCs to accomplish the goals of both WIC and a community clinic, while providing high-quality care.
- Use of electronic medical records for improved quality of care.

Public Health Department-WIC-CPSP Collaboration

Santa Barbara County (www.sbchd.org)

The Santa Barbara County Public Health Department (SBCPHD) is a Federally Qualified Health Center, which allows it to bill visits at a higher reimbursement rate.

In January 2006, Medi-Cal regulations changed to allow mid-level providers such as Registered Dietitians (RD) and Health Educators (HE) to be reimbursed at the substantially higher FQHC rate. In July 2006, the SBCPHD enacted this change.

At the SBCPHD, RDs work for the WIC Program, OB/Comprehensive Perinatal Services Program (CPSP), and Primary Care Clinics. They are not housed in a separate department.



Lactation support can be billed for patients who have straight or fee-for-service Medi-Cal as well as those who are on a Managed Medi-Cal Plan. For Santa Barbara County, CenCal Health (formerly the Regional Health Authority) is the local Medi-Cal plan. Both types of Medi-Cal are reimbursed at the FQHC rate. The county's three Lactation Consultants are partially paid by county general fund money. When breastfeeding assessments or follow-ups are completed, the time is billed to the general fund and not to WIC, so there is no double dipping.

Santa Barbara County has other CPSP providers who are not related to the SBCPHD, for which SBCPHD provides CPSP services. State CPSP requires and approves a Dual Provider Agreement (DPA) between each CPSP provider and SBCPHD. For example, Santa Barbara County had four other CPSP providers that were not related to the SBCPHD and Santa Maria had six providers. With the DPA agreement, SBCPHD staff can see mothers who are not County clients and those who have private CPSP doctors.

In order to bill under CPSP, clients who have private doctors who are not approved CPSP providers are brought into the SBCPHD CPSP program. For these clients, a packet of forms is filled out and a supervising county physician needs to sign off on SBCPHD staff notes to the doctor. Although not required, the SBCPHD Breastfeeding Program/WIC has set up MOUs with these providers. A doctor referral is not needed to see a mother, but completed assessments or follow-ups are faxed to the obstetrician and pediatrician to ensure continuity and quality of care.

This model has the following strengths:

- Comprehensive care for breastfeeding support between FQHC, CPSP, and WIC.
- Efficient use of RDs and IBCLCs to accomplish the goals of the FQHC clinic, CPSP programs, and WIC while providing high-quality care.
- The program can bill all postpartum mothers on Medi-Cal, not just mothers in CPSP or county patients.

See Appendix 7, a Santa Barbara WIC-CPSP Template Agreement.

Hospital Outpatient Clinic

Miller Children's Hospital Long Beach Outpatient Clinic

www.millerchildrenshospitallb.org

Support for mothers in the Long Beach area is provided through two breastfeeding outpatient clinics.

The MemorialCare Women's clinic sees patients three days per week. The clinic is staffed by Registered Nurses who are also IBCLCs. The patients may self-refer or be referred by their physician, WIC program, or a lactation consultant.

The other outpatient clinic is for infants discharged from the NICU at Miller. These babies have access to IBCLCs who cover the NICU.

Billing is the same in both clinics. The IBCLCs bill private insurers and Medi-Cal for the services. There is also a cash pay option for patients who do not have insurance. HMO patients must first obtain a referral from their physician before being seen in either clinic. Services are billed as a facility charge rather than a diagnostic code.

The IBCLCs fax completed visit information and feeding plans to the obstetrician and pediatrician after each visit.

This model has the following strengths:

- Patients have access to outpatient lactation support at the hospital.
- The clinic bills for both commercial and Medi-Cal health coverage.
- The clinic is able to assist mothers in obtaining a breast pump and any other items needed for successful breastfeeding.
- Mothers need not deliver at Miller Children’s Hospital to use services of the lactation consultants.

Private Practice IBCLC

Growing with Baby (www.growingwithbaby.org)

Growing with Baby is a breastfeeding practice in San Luis Obispo, run by a solo Pediatric Nurse Practitioner. The practice specializes in feeding issues and parenting challenges. The practitioner is a board certified lactation consultant.

The clinician is contracted with Cencal (HMO Medi-Cal), state Medi-Cal, and a local private HMO insurance company. She successfully bills Blue Cross, although warns patients that she is not a preferred provider. Her Nurse Practitioner status allows her to do independent billing for breastfeeding consultations. Twenty percent of billing is done electronically; the rest are on a CMS-1500 claim that is sent by mail. The provider is identified by her NPI number for most billing except Blue Cross, which requires a federal tax ID number.

The practice is centrally located in the downtown area. A small store in the office supplies consumer breast pumps, rental breast pumps, and breastfeeding supplies, along with nursing bras, infant swaddlers, infant stimulation toys, and relevant books on infant development.

Services include breastfeeding consultations, assistance with expressing breast milk, how to breastfeed while working, bottle feeding issues, and early parenting concerns such as sleep, biting, and discipline. A trained and experienced front-office assistant triages and advises patients, assists with breast pumps, and does the billing. Consultations include a comprehensive history, pertinent physical assessment of the mother and the baby, feeding observation, a written plan for the parents, and a letter to the patient’s physician.

The practice also offers free support groups and special topic classes on sleep, feeding solids, and discipline. The practice has established a pump rental station at one of the local hospitals that has a neonatal intensive care unit. Because some of the patients referred have neurologic and developmental problems, the practitioner has established a relationship with a neurodevelopmental-trained occupational therapist; they see those patients jointly.

Referrals are from local physicians and midwives, local hospitals, and through word of mouth. Many of the clients are mothers returning with their second, third, and fourth baby.

Success of the practice is essentially due to the following: The practitioner has developed trust in the community regarding her skills and knowledge. The Growing with Baby Center is a supportive, accepting environment and a place where parents can stop by and weigh their babies and sit and breastfeed. The practitioner is able to bill private and public insurance, and provides a sliding scale for private patients who have difficulty paying her private pay fees.

This model has the following strengths:

- Personalized non-institutionalized care in a homey setting from a highly educated and experienced nurse practitioner.
- Continuity of care and careful follow-up.
- Patients are usually seen as many times as it takes to resolve the problems.
- Excellent communication between the referring providers and the practitioner.
- A complete evaluation letter sent to all referring sources.
- Support staff who are trained to counsel mothers appropriately and triage the urgency and timing of consultations.
- The ability to bill insurance and receive reimbursement for most lactation-related services, which allows the practice business model to function successfully.



Multi-Partner Collaboration

Downtown Los Angeles Collaboration

Collaborative support for breastfeeding has been established in downtown Los Angeles, providing what should be a sustainable and effective safety net. The partners include California Hospital Medical Center, Eisner Pediatric and Family Medical Center, Public Health Foundation Enterprises WIC (PHFE WIC), Health Net, Healthcare LA Independent Physicians Group, and Apria.

The process of establishing the collaboration was one of identifying existing, or establishing new contracts, MOUs, or verbal agreements to refer mothers for breast pumps or lactation support among the parties. The local breastfeeding advocacy coalition, Breastfeeding Task Force of Greater Los Angeles, played a role in developing the collaboration.

As required in Medi-Cal Managed Care, Health Net and PHFE WIC have established an MOU to provide lactation support. This thoughtfully developed agreement has enabled improved breastfeeding support.

See Appendix 8, Health Net and PHFE WIC MOU

See Appendix 9, Map of Los Angeles Breastfeeding Safety Net

The rest of the safety net was established as lactation staff interfaced with their own organizational staff and the community partners to establish referral systems, breastfeeding phone logs, and regular communications among the organizations.

Currently, when a mother delivers in California Hospital Medical Center and a hospital-grade breast pump is needed, a number of cascading steps occur:

- For mothers on Medi-Cal Managed Care, Health Net plan, Apria, the DME provider is contacted and a pump is delivered to her home within 24 hours.
- If the mother does not have Medi-Cal Managed Care, Health Net, she is referred to PHFE WIC for a breast pump.
- In all cases the mother's primary care clinic, which is often Eisner, and also WIC, are notified that she has a pump so that staff can provide help with proper use of the pump and breastfeeding support.

The safety net organizations provide:

- Education for the proper use of the pump.
- Breastfeeding support at any clinic visit the mother has; if she misses an appointment at one site, the next one knows to ask about her breastfeeding.
- Breastfeeding support shared among all groups, so WIC is not the default.

The partners developed a referral decision tree and referral form from the hospital to help identify the proper referral process based on the health plan coverage.

See Appendix 10, Los Angeles Breastfeeding Referral Tree

See Appendix 11, Hospital Breast Pump Referral Form

See Appendix 12, Hospital Breast Pump Referral Form

It is critical to understand or establish the contracts, MOUs, and agreements among parties to provide support. Two template tools are provided for use in your community.

See Appendix 13, Template for Community Collaboration

See Appendix 14, Template for Breastfeeding Referral Tree

This model has the following strengths:

- The major community partners have committed to support breastfeeding.
- Breastfeeding support is shared by all, so there is less chance a mother will not receive support to reach her breastfeeding goal.

Getting Started

Collaborations among local providers focused on including lactation consultant services are helping California mothers engage in and sustain their breastfeeding efforts. A number of models already in operation show the variety of ways that clinics, hospitals and private providers are improving breastfeeding outcomes. Where they exist, local breastfeeding coalition members can be key partners in identifying organizations to include in a community-based breastfeeding network. Much of the work involved in establishing the safety network revolves around developing relationships through communications, contracts, memorandums of understanding and referral tools. With the rollout of electronic medical records, these safety nets should be even easier to establish.

Breastfeeding advocates can take the following steps to get started:

1. Set up a meeting or phone conference with potential partners from hospitals, clinics, WIC agencies and health plans to discuss the safety net in your locale.
2. Using the templates and sample models of this Toolkit as a starting point, discuss the following topics:
 - How referrals for lactation support and breast pumps are currently made between organizations in your community
 - How Medi-Cal and the health plans cover support for lactation consults and pumps for mothers
 - Possibilities for making referrals for lactation support and pumps and sharing support between Medi-Cal and WIC
3. Identify what contracts, memorandums of understanding, and agreements are in place.
4. Identify what linkages need improvement and what tools will build that agreement. Is a contract or memorandum of understanding needed, or a simple agreement? Is a referral tool needed?
5. Identify where you need to gather more information or develop a linkage.
6. Get commitment from members of the group for future meetings to work on specific tasks related to lactation support and community referrals and linkages using Medi-Cal in addition to WIC.

NOTES

1. California WIC Association. 2006. Overcoming Barriers to Breastfeeding in Low-Income Women, A Policy Brief on Preventing Obesity in Early Childhood.
2. California WIC Association and UC Davis Human Lactation Center. 2011. One Hospital at a Time: Overcoming Barriers to Breastfeeding. http://www.calwic.org/storage/documents/factsheets2011/CALWIC_One_Hospital_2011.pdf.
3. See the California Law at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=01001-02000&file=1030-1033>.
4. See the website for Health Care Reform at <http://www.healthcare.gov/prevention/index.html>.
5. See the Federal Law at <http://www.dol.gov/whd/regs/compliance/whdfs73.htm>
<http://www.usbreastfeeding.org/Employment/WorkplaceSupport/FAQsBreakTimeforNursingMothers/tabid/188/Default.aspx>.
6. For more on breastfeeding laws, see www.ncsl.org/default.aspx?tabid=14389.

Appendices

Billing for Lactation Services in CPSP

Pregnancy V22.2	Postpartum V24.2	CPT	# Units	\$/UNIT	Examples of Qualifying Activities
Individual Services					
Client Orientation (Pre/Postpartum)		Z6400	8	\$ 8.41	Assisting pregnant or postpartum woman to access services including pumps, breastfeeding supplies, and donor milk. Referring clients to breastfeeding support resources in the community: peer counseling, La Leche.
Nutrition Follow-Up (Prenatal)		Z6204	8	\$ 8.41	Helping a pregnant woman to understand her nutritional needs during breastfeeding.
Psychosocial Follow-up (Prenatal)		Z6304	12	\$ 8.41	Assisting a pregnant woman who had a negative experience with breastfeeding in the past and is anxious to consider breastfeeding.
Health Education Follow-Up (Prenatal)		Z6406	8	\$ 8.41	All education provided to a pregnant woman; helping a woman who has had a breast reduction, implants or has flat nipples prepare for breastfeeding.
Perinatal Education (Pre/Postpartum)		Z6410	16	\$ 8.41	All education provided to a pregnant &/or postpartum woman.
Nutrition Assessment (Postpartum)		Z6208	4	\$ 8.41	Assisting a new mother determine the nutritional needs of her infant – supplementing a baby in the NICU with donor milk.
Psychosocial (Postpartum)		Z6308	6	\$ 8.41	Providing support to a new mother who is experiencing difficult with a colicky baby; a mother who has experienced a stillbirth and would like to dry up her milk supply.
Health Ed. (Postpartum)		Z6414	4	\$ 8.41	Providing lactation consultation to a women who is having trouble with latch
Group Services					
Nutrition Follow-Up (Prenatal)		Z6206	12	\$ 2.81	Breastfeeding class to expectant parents to prepare them for postpartum experience.
Psychosocial Follow-Up (Prenatal)		Z6306	16	\$ 2.81	Including a component on the need for psychosocial support in the breastfeeding class provided to expectant parents.
Health Education Follow-Up (Prenatal)		Z6408	8	\$ 2.81	All education provided to a group of pregnant women.
Perinatal Education (Pre/Postpartum)		Z6412	72	\$ 2.81	All education provided to a group of pregnant &/or postpartum women.

Notes:

- Services are only reimbursable for outpatients women enrolled in CPSP.
- Clients must have received an initial CPSP assessment.
- 1 Unit = 15 minutes; 0-7' = not payable, 8-22' = 1 unit, 23-37' = 2 units, 38-52' = 3 units
- CPSP services are covered 60 days from the last day of the month in which the mother delivers.
- Documentation of services must include date, description, signature, CPSP title and minutes of face to face services.

Appendix 2 ~ Sample Billing Form for Group Education

Date: _____ Infant Medical Record #: _____

Breastfeeding Support Group First Visit

Mother's Name: _____ Birth Date: _____
Baby's Name: _____ Birth Date: _____
Birth Weight: _____ Enrolled in WIC? _____

Peer Counselor: _____
Is this your first baby? _____ If no, how long did you breastfeed? _____
Describe why you are here today: _____

Assessments: _____

Interventions:

Wt: _____ with clothes: _____ naked: _____ positioning and latch techniques: _____
Tx for Engorgement: _____ Tx for Sore Nipples: _____ SNS: _____ Finger Feeding _____
Bottle Feeding: _____ Nipple Shield: _____ Pumping: _____ Burping: _____ Tx for Thrush: _____
Tx for plugged milk ducts/mastitis: _____ Emotional/Psychosocial Support: _____
Other: _____

Discussed:

Frequency & Duration of Fdgs: _____ Receiving Adequate Nutrition: _____
Burping: _____ Sucking Pattern: _____ Infant Behavior: _____ Feeding Cues: _____
Cluster Feeding: _____ Infant comfort techniques: _____ Growth Spurts: _____
Increasing Milk Supply: _____ Going Back to Work: _____ Breast Pumps: _____
Pumping: _____ Storage of Milk: _____ Pacifiers: _____ Basic Maternal Diet: _____
S/S intolerance and Tx: _____ Tx overabundant supply: _____
Other: _____

Follow Up: _____

Health Care Provider(s) signature: _____
Title _____

Time class starts _____ Time class ends _____ Minutes spent in 1:1 _____
Focus of face-to-face encounter: Health Ed: _____ Psych/Social: _____ Nutrition: _____
Handouts used (can list usual materials then just circle): _____

CPSP Documentation needs to include:

Assessment/Dx/Tx:
Actual minutes spent in face-to-face encounter
Identify which category: HE/ PS / Nut
Document class attendance in the progress note
Follow up plan:
Sign (name & title) and date

*The number of minutes billed should not exceed the actual number of minutes of the class.

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

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 reimbursed appropriately.

This pamphlet is a guide to help pediatric practitioners get 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 standard CPT codes, e.g., 99212–99215
- Use standard ICD-9-CM codes, e.g., 779.3 or 783.3
- Code based on time, if greater than 50% of time is spent in counseling, education, or coordination of care
- Use modifier 25 appended to a separately reported office or other outpatient service to bill for extended time spent on feeding problems at a well baby visit.
- Bill for care provided for the mother, often as a new patient, in addition to billing for the baby, if history, exam, diagnosis and treatment are done for her.

The practice can also, under specific circumstances, charge for services provided by nurses and such allied health professionals as lactation consultants, health educators, and nutritionists, using a variety of codes.

This pamphlet discusses:

1. Commonly used ICD-9-CM codes
2. Options for billing the three-to-five day visit
3. Billing for extra time spent at well baby visits
4. Use of time-based coding
5. Billing for consults
6. Billing for care provided for the mother
7. Billing for allied health professional services

*Unless restricted by their state or payors' scope of practice limitations. This pamphlet does NOT discuss the detailed, important and specific guidelines affecting decisions about billing for nurse practitioners and physician assistants, i.e., 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 pamphlet. However, all physicians employing such allied health care providers need to be aware of, and understand, the applicable billing rules, and apply them carefully—whether billing for feeding problems, or for any other medical services in the pediatric office.

Commonly used ICD-9-CM codes

Baby

Feeding problems

Feeding problem or vomiting, newborn	779.3
Feeding problem, infant (> 28 days)	783.3
Vomiting, infant (> 28 days)	787.03

Jaundice

Breastmilk jaundice	774.39
Neonatal jaundice	774.6
Preterm jaundice	774.2

Weight and hydration

Dehydration, neonatal	775.5
Weight loss	783.21
Underweight	783.22
Slow weight gain, FTT	783.41
Rapid weight gain	783.1

As well as all the diagnoses associated with size and maturity.

Infant distress

Fussy baby	780.91
Excessive crying	780.92
Infantile colic or intestinal distress	789.07

GI issues

Change in bowel habits	787.99
Abnormal stools	787.7
Diarrhea	787.91

Mouth

Ankyloglossia	750.0
High arched palate	750.26
Other specified follow-up exam (When the original reason for visit has resolved)	V67.59

Mother

Breast issues

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

Burning pains, hyperesthesia	782.0
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

Constitutional

Disrupted sleep cycle	780.55
Fatigue	780.79

Lactation

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
Other specified follow-up exam (When the original reason for visit has resolved)	V67.59

The three- to five-day visit

The AAP recommends ^{1,2,3} this visit

- 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 production.

This assessment usually 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 weights before and after feeding
4. Testing, interventions, and counseling if indicated

The visit may be billed as either

- a first routine well visit OR
- a follow-up visit, for a problem noted earlier

Billing as a well 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 well-child visit.*

- CPT code 99391
- ICD-9-CM V20.2 (and any other indicated diagnosis codes, e.g., for jaundice or feeding problem)

In any well visit, the clinician 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 which requires *more* than an ordinary amount of time to address, the physician may, depending on the circumstances, 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 on the next page
- Schedule a follow-up visit, for example, within a few days, or at one to two weeks of age. That follow-up visit would then be billable using the office follow-up codes (99211-99215) related to that feeding problem diagnosis.

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 on the preceding health or hospital record.

- The earlier chart must document the unresolved problem that requires a follow-up visit.
- An appropriate diagnosis code, e.g., “newborn feeding problem” (779.3), or “jaundice” (774.6) must be included with the hospital or birth center's discharge diagnoses, to establish the reason for the follow-up visit.
- Alternatively, telephone chart notes document that, since discharge, a new problem exists.

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%
- Breastfed infant being fed formula

Options for coding and billing as a follow-up visit:

1. Schedule routinely with physician or billable licensed health care provider (e.g., NP or PA):

Use office follow-up codes 99212–99215 and appropriate ICD-9-CM codes:

- If the feeding problem persists, use an ICD-9-CM such as 779.3, 774.6, 783.21, etc.
- If, however, the feeding problem has resolved, use instead ICD-9-CM code V67.59, 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 to the nurse as a 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 to bill for a limited nurse's visit with CPT code 99211 and ICD-9-CM code V67.59.
- b. *If nurse's weight check visit reveals persistent problems*, you do NOT bill for the nurse visit but instead triage back to pediatrician, or other billable health care practitioner (NP or PA) immediately for a problem visit, billable as a follow-up visit (99212–99215)

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*. 1995;96:788-790

Billing for extra time spent on feeding problems at any well baby visit

If, at a well visit, a significant, separately identifiable, diagnosable feeding *problem* necessitates extra time beyond routine well visit feeding counseling, then the 99212-99215 codes appended with the modifier 25 may be reported in addition to the preventive medicine service code.

A separate note is optimally written, on a separate page or on the same page with a line separating the two notes: the well visit note and the problem based note.

Furthermore, 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 billed, adding the modifier 25 to the acute visit code. Billing might then be, *for example*:

99391 **V20.2**
99213-25 **779.3** [or 783.3 if over 28 days]

Note: Some insurers do not accept the modifier 25.

Billing for any clinician’s visit based on time

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

The CPT guidelines allow for a visit to be billed based on time, rather than by meeting the E/M requirements for elements of history, physical, and decision-making, *if*:

1. More than 50% of the practitioner’s face-to-face time with the patient has been spent on counseling (patient education) or coordination of care
2. You must document *on the chart*:
 - a. Your total face-to-face time with the patient and/or the patient’s family.
 - b. Time spent in counseling or coordination of care (and this must be > 50% of total)
 - c. A brief description of what was discussed (should be one or more: diagnosis or impressions; prognosis; risks/benefits of management options; instructions for management and follow-up; compliance issues; risk factor reduction; patient and family education); a checklist on your encounter form will make this easier for all time-based visits, not just those about breastfeeding issues

You can bill for time for most routine E/M codes, e.g., 99212–99215, when counseling, education, or coordination of care dominate a visit otherwise not meeting customary guidelines for history, physical, and medical decision-making. (but it should be noted that time-based billing cannot be used with the preventive medicine service codes, since their CPT code descriptors do not contain “typical times”)

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

	<i>New</i>		<i>Established</i>		<i>Outpatient</i>
	<i>Patient</i>	<i>Time</i>	<i>Patient</i>	<i>Time</i>	<i>Consult</i>
					<i>Time</i>
99202	20	99212	10	99241	15
99203	30	99213	15	99242	30
99204	45	99214	25	99243	40
99205	60	99215	40	99244	60
				99245	80

[*For example*, if you spent 30 minutes face to face with an established baby and mother, of which greater than 15 minutes were spent counseling about feeding issues, you could bill with CPT code 99214, ignoring the usual history, exam, and medical decision-making requirements for a 99214. Your chart documentation must include the three elements described above: total physician face-to-face time, total time spent counseling, and a description of that counseling.]

Consultations

The physician or individually credentialed nurse practitioner or physician’s 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 even a La Leche League leader) is documented
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 will be billed as established patients (99212–99215).

* An allied health care provider cannot bill a consult under the “incident to” billing options. Only a nurse practitioner or physician’s 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 payor limitations.

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 for her, the clinician is treating a second patient. This may change the visit with the baby into two separate and identifiable visits with two different patients—two patients, two visits, two records, two bills, and two co-pays.

- Depending on the mother's insurance, you may need to get a request from her primary care health care provider.
- Can be billed either as a new patient (99201–99205) or, if you have a request and will make a written report back to the requesting source, as a consult (99241–99245)

Billing for services by allied health providers who are neither nurse practitioners nor physician's assistants

Services provided by an allied health professional who is *not* a billable and credentialed nurse practitioner or physician's assistant, (e.g., a nurse, health educator, or lactation consultant) can be billed two ways.

- 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, baby, 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.

B. Health and Behavior Assessment and Intervention codes

After a breastfeeding (or any other health) problem has been established *by the physician*, an allied health provider may see the patient to focus on “the biopsychosocial factors, important physical health problems, and treatments” (the AMA's CPT 2006 manual, page 399). The following conditions apply:

1. *These require a medical condition* (e.g., feeding problem or low weight gain) **previously diagnosed by the physician at an earlier date.**
2. These health and behavior visits may not be reported on the same day as any other E/M service.
3. These visits are not for generalized preventive counseling or risk factor reduction.
4. These are billable in 15-minute time increments, based on the allied health professional's time (they are not for use by physicians or other billable licensed health care provider). If honored by the insurer, these codes are well reimbursed and are a good way to pay for your office lactation consultant who is not otherwise licensed or credentialed for billing.

Codes

- **96150** Initial health and behavior assessment (clinical interview, behavioral observations, health questionnaires, etc.):
Each 15 minutes face-to-face time
- **96151** Reassessment
- **96152** Health and behavior intervention, individual
Each 15 minutes face-to-face time
- **96153** Health and behavior intervention, group (two or more patients)
Note: you will need a group of five or six to be reimbursed for the allied health professional's time equivalently to the individual or family sessions.
Each 15 minutes face-to-face time
- **96154** Health and behavior intervention, family, with patient present
Each 15 minutes face-to-face time
- **96155** Health and behavior intervention, family, without patient present
Each 15 minutes face-to-face time

Billing for phone calls and online communications

Certain non-face-to-face services codes have been updated for 2008. The updated E/M codes for telephone and online medical discussions permit billing for both physician services and services provided by “qualified non-physician health care professional(s)”.

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. (The online E/M codes do not carry this restriction.)

Note: Not all insurers reimburse for these codes.

Telephone Calls

Provided the criteria above are met, telephone calls may be billed using the following codes:

Medical Discussion in minutes	Physician Calls	Non-physician Provider Calls
5-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968

Online Medical Evaluations

E/M services

- provided to an established patient, or to that patient’s parent, guardian or health care provider
- using the internet or similar electronic communications network
- not originating from a related E/M service in the previous 7 days

may be billed, regardless of length, using codes

- 99444 for services provided by a physician
- 98969 for services provided by a qualified non-physician health care professional.

Billing for interdisciplinary team conferences

The codes for billing for participation in interdisciplinary medical team conferences attended by other health professionals have been updated for 2008.

To bill for participation in team meetings when the patient or family is present

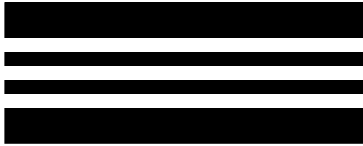
- Physicians continue to use regular E/M codes, e.g. 99214 or 99215, using time as the controlling factor, based on face-to-face time spent on “counseling and coordination of care.”
- To bill for participation by non-physician qualified health care professionals, use 99366 for meetings of 30 minutes 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

Appendix 4 ~ Health Insurance Claim Form 1500

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM																						
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)												
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)												
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE											
ZIP CODE			TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (INCLUDE AREA CODE) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER												
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME												
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME												
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>												
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												
SIGNED _____ DATE _____										SIGNED _____												
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										23. PRIOR AUTHORIZATION NUMBER												
24. A DATE(S) OF SERVICE		B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE	
From MM DD YY To MM DD YY																						
1																						
2																						
3																						
4																						
5																						
6																						
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #							
SIGNED _____ DATE _____										PIN# _____					GRP# _____							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

STATE OF CALIFORNIA MEDI-CAL
Product Specification
Single-User Personal Double Electric Breast Pumps

DRAFT/proposed June 7, 2010

1.0 SCOPE This specification establishes requirements for single-user personal double electric breast pumps.

2.0 GENERAL REQUIREMENTS

- 2.1** All furnished components including all utility connections shall be new and comply with all applicable California, State and Federal Administrative Codes.
- 2.2** Entire product shall be UL Listed or UL Classified [Nationally Recognized Test Laboratory (NRTL) equivalent is acceptable].
- 2.3** FDA 510(k) clearance to market product.
- 2.4** Product shall be safe and effective for its intended use.

3.0 PRODUCT DESCRIPTION

3.1 Assembly

3.1.1 The assembly shall include but not be limited to the following components:

- Pump-motor unit
- Minimum 5'-long electric cord
- Double pumping kit

3.1.2 The total weight of the furnished assembly shall not exceed 10 lb.

3.2 Operational and configuration

3.2.1 The product shall operate at the following vacuum range for both single and double pumping:

Minimum vacuum setting: 50-130mmHg

Maximum vacuum setting: 210-250mmHg

3.2.2 Fixed and/or adjustable pulsating suction frequency of 40-78 cycles per minute.

3.2.3 The pump suction shall have an auto-release function.

3.2.4 The product shall have single and double pumping capacity and shall be capable of maintaining a consistent vacuum as the collection container fills with milk, regardless of the container size and single or double pumping.

3.2.5 The double pumping capacity shall be simultaneous, not alternating.

3.2.6 The breastmilk pathway shall be visible and no milk shall be able to contact internal pump-motor unit parts at any time when product is used per manufacturer instructions.

3.2.7 Manufacturer is permitted to offer battery option.

4.0 COMPONENTS

4.1 Pump-motor unit

The pump-motor unit of minimum 6 watts shall operate with 1 phase, 110/120 VAC, 60 HZ power input.

4.2 Double pumping kit

- 4.2.1 The breastmilk pumping kit shall include all accessories necessary for single and double pumping and at least two minimum 4 fl. oz. translucent/transparent, threaded to milk-collecting containers with mating leak free storage caps.
- 4.2.2 Design and materials of the furnished assembly shall allow viewing the breastmilk pathway.
- 4.2.3 The pump flanges shall not have sharp edges.
- 4.2.4 The manufacturer is allowed to offer various flange sizes.
- 4.2.5 The nipple tunnel shall not deflect inward more than 50% of its original diameter if pump flange is under a maximum pumping cycle vacuum, unless it is made of soft material contouring to the mothers' breast, ensuring a proper, comfortable fit and appropriate milk volume output.
- 4.2.6 The pump shall be protected from milk backing into the internal pump-motor unit.
- 4.2.7 All milk contacting components shall be dishwasher safe and capable of maintaining integrity and functionality after daily sanitation in boiling water bath during a specific warranty period.
- 4.2.8 Filters used to protect the internal pump-motor unit must be readily cleanable or at least two (2) spare filters shall be provided with each pump.
- 4.2.9 The kit components contacting the mother's breast shall meet applicable bio-compatibility requirements of ISO 10993-1.
- 4.2.10 The kit components contacting mother's milk shall be BPA free and shall meet applicable FDA food contact requirements.
- 4.2.11 The kit components contacting mother's milk shall meet US Consumer Product Safety Improvement Act (USCPSIA), 2008 including requirements for lead and phthalate content as well as CA AB 1108 requirements for DEHP and other phthalates.

5.0 WARRANTY

- 5.1** All components will be guaranteed against failure from faulty design, materials or workmanship for a period of not less than ninety (90) days on parts and 1 year on the pump-motor from the date of distribution to the end user.
- 5.2** Any component(s) exhibiting or failing of design/materials/workmanship defect during the warranty period shall be repaired or replaced by the supplier/manufacturer without cost to the customer during the next business day after receiving failure notification.
- 5.3** Manufacturer reserves the right to process defective pump for Corrective & Preventive Action (CAPA) and to ensure there was no abuse by consumer. If there is evidence of abuse, manufacturer can bill for repair.

6.0 USER'S GUIDE

- 6.1** The user's guide shall include clear illustrations and instructions for the product assembly, use, and cleaning, and breastmilk collecting, handling and storage recommendations.
- 6.2** The instructions shall be in English and Spanish, comprehensive for the 4th -6th grade reading level.
- 6.3** Contact information shall offer a technical assistance toll-free phone number

Appendix 6 ~ Hospital Request for Milk Form

MMB

MOTHERS'
MILK BANK

at Valley Medical Center
established 1974

Pauline Sakamoto,
Executive Director

R.N., M.S. Ron Cohen, M.D.
Medical Director

HOSPITAL REQUEST FOR MILK

IMPORTANT: Orders need to be placed by 11am (PST) Monday – Thursday for next day delivery. Please place orders two days in advance, if possible.

Date of Order: _____

Name of Hospital: _____

Dept. / Unit: _____

Contact Person: _____ Phone: _____

Address _____ Email: _____

City _____ State: _____ Zip: _____

Ordering Physician: _____

Is this for: Mature Infants Preterm Infants

Purchase Order Number: _____

Bottle Size: Hospital Grade 2oz Cost: \$4/oz

Total ounces requested: _____

Bottle Size: Hospital Grade 4 oz Cost: \$3/oz

**In the event of a shortage
of donor breast milk,
can we substitute 4 oz
Hospital-grade milk with
4 oz Mature Grade milk?**

Yes No,

Hospital-grade is mandatory

(Continued on next page)

Total ounces requested: _____ Delivery Date Requested:

SHIPPING INFORMATION:

Hospital Shipping Account Number _____ Fed Ex

Ship to:	Bill to:
----------	----------

For Questions, please contact:

Milk Orders Attn: Valerie Hale Phone: (408) 998-4550 Email: Valerie.Hale@hhs.sccgov.org Toll Free (877) 375-6645	Billing: Attn: Linda Gonzales Phone: (408) 885-3774 Email: Linda.Gonzales@hhs.sccgov.org Toll Free (877) 375-6645
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Appendix 7 ~ Santa Barbara WIC-CPSP Template Agreement

**Agreement
between
Santa Barbara County Public Health Department
and
[MEDICAL PROVIDER]
for the provision of services under the
COMPREHENSIVE PERINATAL SERVICE PROGRAM**

This Agreement (hereafter Agreement) is made by and between the County of Santa Barbara-Public Health Department, a political subdivision of the State of California (hereafter COUNTY-PHD) and XXXXXXXX (hereafter MEDICAL PROVIDER) having its principal place of business at XXXXX wherein COUNTY-PHD agrees to provide breastfeeding services to clients of the Comprehensive Perinatal Service Program (hereafter CPSP) as specified herein.

WHEREAS, access to qualified, bilingual Lacion Consultants is difficult to obtain in Santa Barbara County, and

WHEREAS, the COUNTY-PHD employs qualified, Spanish-speaking, International Board-Certified Lacion Consultants (IBCLCs) that provide breastfeeding consults and follow-ups to CPSP clients in the Public Health Clinics and/or Women, Infants, Children (WIC) sites, and

WHEREAS, The IBCLCs are also Registered Dietitians (RD) or Comprehensive Perinatal Service Workers (CPSW) who may work in either the CPSP program, the Primary Care Clinics or in the WIC program, and

WHEREAS, the COUNTY-PHD receives referrals for breastfeeding services from various sources including CPSP program, the Women, Infant, Children (WIC) program and Obstetricians and Pediatricians in the Community, and

WHEREAS, countywide access to Lactation Consultants employed at COUNTY-PHD insures that more families will receive breastfeeding support;

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, the parties agree as follows:

1. **DESIGNATED REPRESENTATIVES.** Meg Beard MPH, CHES, RD, IBCLC at phone number (805) 681-5276 is the representative of COUNTY-PHD and will administer this Agreement for and on behalf of the COUNTY-PHD. XXXX at phone number (805) xxx-xxxx is the authorized representative for MEDICAL PROVIDER. Changes in designated representatives shall be made only after advance written notice to the other party.

2. **NOTICES.** Any notice or consent required or permitted to be given under this Agreement shall be given to the respective parties in writing, by first class mail, postage prepaid, or otherwise delivered as follows:

To COUNTY-PHD: Meg Beard, MPH, CHES, RD, IBCLC
Nutrition Services
315 Camino del Remedio
Santa Barbara, CA 93110

To MEDICAL PROVIDER: XXXX
XXXX
XXXX

XXXX

or at such other address or to such other person that the parties may from time to time designate. Notices and consents under this section, which are sent by mail, shall be deemed to be received five (5) days following their deposit in the U.S. mail.

3. **SCOPE OF SERVICES.** COUNTY-PHD agrees to provide services in accordance with EXHIBIT A attached hereto and incorporated herein by reference. MEDICAL PROVIDER agrees to provide services in accordance with EXHIBIT A attached hereto and incorporated herein by reference.

4. **TERM.** This Agreement shall commence on XXXX, 2007 and continue from year to year until either party provides written notice of termination as provided in Section 10 hereto. COUNTY-PHD shall notify the appropriate CPSP certification body of the State of California upon termination of this Agreement by either party.

5. **COMPENSATION OF COUNTY.** COUNTY-PHD will provide services as outlined in Exhibit A without compensation from MEDICAL PROVIDER. COUNTY-PHD will not be prohibited from seeking compensation from State and Federal sources. County will bill for services rendered to all sources. County also has programs available to assist those with financial hardship that meet certain criteria with access to breastfeeding services.

6. **INDEPENDENT CONTRACTOR.** COUNTY-PHD and MEDICAL PROVIDER agree that the relationship created by this Agreement is that of two independent contracting parties. At no time whatsoever shall MEDICAL PROVIDER or MEDICAL PROVIDER employees be regarded as agents, servants or employees of the COUNTY-PHD as a result of the services performed pursuant to this Agreement.

7. **STANDARD OF PERFORMANCE.** COUNTY-PHD represents that it has the skills, expertise, and licenses/permits necessary to perform the services required under this Agreement. Accordingly, COUNTY-PHD shall perform all such services in the manner according to the standards observed by a competent practitioner of the same profession in which the COUNTY-PHD is engaged. All products of whatsoever nature, which COUNTY-PHD delivers pursuant to this Agreement, shall be prepared in a first class and workmanlike manner and shall conform to the standards of quality normally observed by a person practicing in COUNTY-PHD's profession. COUNTY-PHD shall correct or revise any errors or omissions, at MEDICAL PROVIDER's request without additional compensation. Permits and/or licenses shall be obtained and maintained by COUNTY-PHD without additional compensation.

COUNTY-PHD shall deliver services according to site-specific protocols as defined in Title 22, CCR, Section 51179.9.

8. **INSURANCE.** The County of Santa Barbara is self-insured for any general, automobile, professional and/or medical malpractice liability losses up to \$500,000 per occurrence combined single limit for bodily injury and property damage. In addition, the County is permissibly self-insured for any workers' compensation loss. The County purchases excess liability insurance with limits in excess of \$1,000,000 through the CSAC Excess Insurance Authority, a joint power authority.

9. **ASSIGNMENT.** COUNTY-PHD shall not assign any of its rights nor transfer any of its obligations under this Agreement without the prior written consent of MEDICAL PROVIDER and any attempt to so assign or so transfer without such consent shall be void and without legal effect and shall constitute grounds for termination.

10. **TERMINATION.** Either party may terminate this Agreement upon sixty (60) days written notice to the other party.

11. **SEVERABILITY.** If any one or more of the provisions contained herein shall for any reason be held to be invalid, illegal or unenforceable in any respect, then such provision or provisions shall be deemed severable from the remaining provisions hereof, and such invalidity, illegality or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

12. **NO WAIVER OF DEFAULT.** No delay or omission of COUNTY-PHD to exercise any right or power arising upon the occurrence of any event of default shall impair any such right or power or shall be construed to be a waiver of any such default or an acquiescence therein; and every power and remedy given by this Agreement to COUNTY-PHD shall be exercised from time to time and as often as may be deemed expedient in the sole discretion of COUNTY-PHD.

13. **ENTIRE AGREEMENT AND AMENDMENT.** In conjunction with the matters considered herein, this Agreement contains the entire understanding and agreement of the parties and there have been no promises, representations, agreements, warranties or undertakings by any of the parties, either oral or written, of any character or nature hereafter binding except as set forth herein. This Agreement may be altered, amended or modified only by an instrument in writing, executed by the parties to this Agreement and by no other means. Each party waives their future right to claim, contest or assert that this Agreement was modified, canceled, superseded, or changed by any oral agreements, course of conduct, waiver or estoppel.

14. **SUCCESSORS AND ASSIGNS.** All representations, covenants and warranties set forth in this Agreement, by or on behalf of, or for the benefit of any or all of the parties hereto, shall be binding upon and inure to the benefit of such party, its successors and assigns.

15. **CALIFORNIA LAW.** This Agreement shall be governed by the laws of the State of California. Any litigation regarding this Agreement or its contents shall be filed in the County of Santa Barbara, if in state court, or in the federal district court nearest to Santa Barbara County, if in federal court.

16. **AUTHORITY.** All parties to this Agreement warrant and represent that they have the power and authority to enter into this Agreement in the names, titles and capacities herein stated and on behalf of any entities, persons, or firms represented or purported to be represented by such entity(ies), person(s), or firm(s) and that all formal requirements necessary or required by any state and/or federal law in order to enter into this Agreement have been fully complied with. Furthermore, by entering into this Agreement, MEDICAL PROVIDER hereby warrants that it shall not have breached the terms or conditions of any other contract or agreement to which MEDICAL PROVIDER is obligated, which breach would have a material effect hereon.

17. **PRECEDENCE.** In the event of conflict between the provisions contained in the numbered sections of this Agreement and the provisions contained in the Exhibits, the provisions of the Exhibits shall prevail over those in the numbered sections.

18. **CONFIDENTIALITY.** COUNTY-PHD and MEDICAL PROVIDER agree that the client's personal health information (PHI) will be used for treatment purposes only in compliance with the Health Insurance Portability and Accountability Act (HIPAA). COUNTY-PHD is considered to be a "Hybrid Entity" under HIPAA, 42 U.S.C. 1320d et seq. and its implementing regulations including but not limited to 45 Code of Federal Regulations parts 142, 160, 162, and 164, ("Privacy Rule and Security Rule"). MEDICAL PROVIDER is considered to be a "Business Associate" under the Privacy Rule. MEDICAL PROVIDER must also comply with the Security

Rule as a Business Associate, if under this Agreement; it receives, maintains or transmits any health information in electronic form in connection with a transaction covered by part 162 of title 45 of the Code of Federal Regulations. COUNTY-PHD and MEDICAL PROVIDER acknowledge that HIPAA mandates them to enter into a business associate agreement in order to safeguard protected health information that may be accessed during the performance of this Agreement. The parties agree to the terms and conditions set forth in the HIPAA Business Associate Agreement, attached hereto as Exhibit B.

- A. COUNTY-PHD and MEDICAL PROVIDER agree to take all reasonable precautions to prevent any unauthorized disclosure of confidential information per California Health and Safety Code section 120440.
- B. The foregoing restrictions on disclosure shall survive the termination, expiration or cancellation of this agreement. COUNTY and MEDICAL PROVIDER agree not to sell, disclose or otherwise make the data available to others or use the data for soliciting or for any commercial purpose.
- C. COUNTY-PHD and MEDICAL PROVIDER agree that its personnel will comply with the following security regulations:
 - 1) Require all users, as a prerequisite of being granted access to such data, to sign statements, acknowledging their understanding that unauthorized use of such data or disclosure of such data to unauthorized parties is forbidden; and
 - 2) Provide reasonable physical security at facilities to limit access to the data; and
 - 3) Safeguard user ID and password against unauthorized use; and
 - 4) Take the same care to prevent unauthorized disclosure of the data that it takes to protect other information, data or tangible or intangible property of its own that it regards as proprietary or confidential.
- D. COUNTY-PHD and MEDICAL PROVIDER shall promptly inform the other party of any breach of confidentiality that has occurred.
- E. COUNTY-PHD and MEDICAL PROVIDER agree that all information and records obtained in the course of providing services to protect clients shall be subject to confidentiality and disclosure provisions and applicable Federal and State Statutes and Regulations.
- F. Any of the information shared will be treated as confidential medical information and used only to help provide immunization services to the patient, or to issue reminder notifications or conduct data analysis and program monitoring.
- G. If the patient or the patient's parent/guardian refuses to allow the information to be shared, the MEDICAL PROVIDER shall not share this information.

Agreement between COUNTY-PHD and MEDICAL PROVIDER for the provision of services under the Comprehensive Perinatal Service Program.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the date executed by COUNTY-PHD.

MEDICAL PROVIDER

(Medi-Cal Provider Number: xx-FHC xxxxxx
National Provider ID Number: xxxxxxxxxxxx)

Name Date

Title

Name of MEDICAL PROVIDER

SUPERVISING PHYSICIAN

(Medi-Cal Provider Number: xx-FHC xxxxxx
National Provider ID Number: xxxxxxxxxxxx)

Name Date

Title

Name of MEDICAL PROVIDER

COUNTY-PHD

(Medi-Cal Provider Number: 42-FHC 70022F
National Provider ID Number: xxxxxxxxxxxx)

Elliot Schulman, MD, MPH, Director Date
Public Health Department

The Public Health Director is authorized to execute this standard Agreement by the COUNTY Board of Supervisors – see Minute Order dated XXXX, 2007.

**EXHIBIT A
STATEMENT OF WORK**

COUNTY-PHD agrees to accept the following terms and responsibilities:

1. Lactation Consultants (RD/CPSW) employed by COUNTY-PHD will be supervised by and report directly to Meg Beard, MPH, CHES, RD, IBCLC.
2. Provide breastfeeding assessment and follow-up to prenatal and postpartum clients within Santa Barbara County during business hours: 9:00 a.m. to 5:00 p.m. Monday through Friday.
3. Reimbursable nutrition services to support breastfeeding shall include but are not limited to:
 - Persistent discomfort to the woman while breastfeeding
 - Infant weight gain concerns
 - Milk extraction
 - Lactation management
 - Suck dysfunction of the infant
4. Complete a Breastfeeding Consultation Report/Individualized Care Plan for each client after each visit.
5. The Report/Plan will indicate if further intervention or urgent attention by the Obstetrician or Pediatrician is recommended.
6. In the case of a breastfeeding emergency, will contact the Physician while completing the breastfeeding assessment.
7. Fax the Report/Plan to the Obstetrician and Pediatrician for inclusion in the client's medical chart.
8. Fax Report/Plan to other providers as necessary for psychosocial, nutrition or diabetes services.
9. After each breastfeeding consult or follow-up, the COUNTY-PHD will complete a county superbill. On a weekly basis, the superbill will be turned into the appropriate COUNTY-PHD coding specialist to be processed. The COUNTY-PHD will bill prenatal breastfeeding services under code 59603-Nutrition Counseling and post-partum breastfeeding services under code 59605-Postpartum Nutrition.
10. Directly bill CPSP for all services provided including but not limited to in-person breastfeeding assessments and follow-ups.
11. Retain a signed copy of the Patient's Release of Records.

MEDICAL PROVIDER agrees to accept the following terms and responsibilities:

1. Serve as Case Coordinator for the CPSP services and inform clients of their role as Case Coordinator.
2. Provide the following services as Case Coordinator: orientation, initial, trimester and postpartum assessments, care plan and interventions.
3. Provide the client with contact information for breastfeeding services of COUNTY-PHD.
4. Act as the supervising physician for breastfeeding services and follow-ups.
5. Directly bill CPSP for all services provided excluding in-person breastfeeding services.

Both parties agree to the following terms and conditions:

Agreement for CPSP services between COUNTY-PHD and
XXXXXXX

BILLING

1. MEDICAL PROVIDER will bill CPSP for all Obstetrician and other CPSP services that are provided by MEDICAL PROVIDER excluding breastfeeding services.
2. COUNTY-PHD will bill CPSP for CPSP services provided including but not limited to in-person breastfeeding assessments and follow-ups.
3. Pursuant to CCR Section 51504 "Comprehensive Perinatal Services", the service limits as specified for an individual patient will not be exceeded except as allowed under FQHC/RHC regulations.
4. COUNTY-PHD and MEDICAL PROVIDER will ensure that duplicate billing of services will not occur.
5. No global billing will occur by either provider.
6. If only one CPSP provider provides the Obstetrician portion of care, global billing is allowable.
7. When billing for a CPSP service which has a prerequisite requirement that has been performed and billed by another provider, the biller must indicate in the "Remarks" portion of the Medi-Cal claim form that the prerequisite service was performed by another provider identified by name and Medi-Cal provider number.

LOCATION FOR APPOINTMENTS

Appointments for breastfeeding services will occur at COUNTY-PHD locations throughout the County.

OPEN REFERRAL

The Agreement will serve as an open referral for services eliminating the requirement for a hard copy referral from the doctor or nurse to COUNTY-PHD for breastfeeding services.

RECIPROCAL CHART REVIEW

Both parties agree to make medical records available for reciprocal chart review pursuant to the confidentiality regulations stated in Section 18 and Exhibit B.

PROCEDURES FOR EMERGENCY BREASTFEEDING PATIENT CARE

When urgent breastfeeding consultation is required on weekends, holidays or weekdays between 5:00 p.m. to 9:00 a.m. the client's physician must be contacted.

MONITORING

To ensure the successful implementation of this Agreement, the services and Agreement will be reviewed and evaluated by both parties one year from the date it becomes effective. If necessary the Agreement will be revised upon mutual agreement.

EXHIBIT B
HIPAA BUSINESS ASSOCIATE AGREEMENT

Celeste – I would like to discuss this with you. N.B. The language here needs to be revised to include both parties as the confidentiality is reciprocal. I will complete this task if the Exhibit is retained.

1. Use and Disclosure of Protected Health Information

Except as otherwise provided in this Exhibit, the Contractor may use or disclose protected health information (“PHI”)¹ to perform functions, activities or services for or on behalf of the County, as specified in the underlying agreement, provided that such use or disclosure does not violate HIPAA or other law. The uses and disclosures of PHI may not exceed the limitations applicable to the County under the regulations except as authorized for management, administrative or legal responsibilities of the Contractor. PHI includes without limitation “Electronic Protected Health Information” (“EPHI”)².

2. Further Disclosure of PHI

The Contractor shall not use or further disclose PHI other than as permitted or required by the underlying Agreement, or as required by law.

3. Safeguarding PHI

The Contractor shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the underlying Agreement. Contractor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI that Contractor creates, receives, maintains or transmits on behalf of County. The actions taken by the Contractor to safeguard EPHI shall include, but may not be limited to:

- a. Encrypting EPHI that it stores and transmits;
- b. Implementing strong access controls, including physical locks, firewalls, and strong passwords;
- c. Using antivirus software that is upgraded regularly;
- d. Adopting contingency planning policies and procedures, including data backup and disaster recovery plans; and
- e. Conducting periodic security training.

4. Unauthorized Use or Disclosure of PHI

The Contractor shall report to the County any use or disclosure of the PHI not provided for by the underlying Agreement or otherwise in violation of the Privacy Rule or Security Rule. Contractor shall report to County any security incidents within 10days of becoming aware of such incidents. For purposes of this paragraph, “security incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

5. Agents and Subcontractors of the Business Associate

The Contractor shall ensure that any agent, including a subcontractor, to which the Contractor provides PHI received from, or created or received by the Contractor on behalf of the County,

¹ “Protected Health Information” means individually identifiable health information including, without limitation, all information, data, documentation and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

² “Electronic Protected Health Information” means Protected Health Information, which is transmitted by Electronic Media (as defined in the HIPAA Security and Privacy Rule) or maintained in Electronic Media.

shall comply with the same restrictions and conditions that apply through the underlying Agreement to the Contractor with respect to such information. The Contractor shall ensure that any agent to whom it provides PHI, including a subcontractor, agrees to implement reasonable and appropriate safeguards to protect such PHI. Contractor shall not use subcontractors or agents, unless it receives prior written consent from County.

6. Access to PHI

At the request of the County, and in the time and manner designated by the County, the Contractor shall provide access to PHI in a Designated Record Set to an Individual or the County to meet the requirements of 45 Code of Federal Regulations section 164.524.

7. Amendments to Designated Record Sets

The Contractor shall make any amendment(s) to PHI in a Designated Record Set that the County directs or at the request of the Individual, and in the time and manner designated by the County in accordance with 45 Code of Federal Regulations section 164.526.

8. Documentation of Uses and Disclosures

The Contractor shall document such disclosures of PHI and information related to such disclosures as would be required for the County to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 Code of Federal Regulations section 164.528. Contractor agrees to implement a process that allows for an accounting to be collected and maintained by Contractor and its agents or subcontractors for at least six years prior to the request, but not before the compliance date of the Privacy Rule.

9. Accounting of Disclosure

The Contractor shall provide to the County or an Individual, in the time and manner designated by the County, information collected in accordance with 45 Code of Federal Regulations section 164.528, to permit the County to respond to a request by the Individual for an accounting of disclosures of PHI in accordance with 45 Code of Federal Regulations section 164.528.

10. Records Available to Covered Entity and Secretary

The Contractor shall make available records related to the use, disclosure, security and privacy protection of PHI received from the County, or created or received by the Contractor on behalf of the County, to the County or to the Secretary of the United State Department of Health and Human Services for purposes of investigating or auditing the County's compliance with the HIPAA privacy and security regulations, in the time and manner designated by the County or the Secretary.

11. Destruction of PHI

a. Upon termination of the underlying Agreement for any reason, the Contractor shall:

- (1) Return all PHI received from the County, or created or received by the Contractor on behalf of the County required to be retained by the Privacy Rule; or
- (2) Return or destroy all other PHI received from the County, or created or received by the Contractor on behalf of the County.

This provision also shall apply to PHI in possession of subcontractors or agents of the Contractor. The Contractor, its agents or subcontractors shall retain no copies of the PHI. However, Contractor, its agents or subcontractors shall retain all protected information throughout the term of the underlying Agreement and shall continue to maintain the information required under Section 8 of this Exhibit for a period of six years after termination of the underlying Agreement.

b. In the event the Contractor determines that returning or destroying the PHI is not feasible, the Contractor shall provide the County notification of the conditions that make return or destruction not feasible. If the County agrees that the return of the PHI is not feasible, the Contractor shall extend the protections of this Exhibit to such PHI and limit further use and disclosures of such PHI for so long as the Contractor, or any of its agents or subcontractors, maintains such PHI.

12. Amendments

The Parties agree to take such action as is necessary to amend the underlying Agreement as necessary for the County to comply with the requirements of the Privacy Rule and its implementing regulations.

13. Mitigation of Disallowed Uses and Disclosures

The Contractor shall mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of the underlying Agreement or the Privacy Rule.

14. Termination of Agreement

The County shall terminate the underlying Agreement upon knowledge of a material breach by the Contractor of which the Contractor fails to cure.

15. Definitions

Terms used, but not otherwise defined, in this Exhibit shall have the same meaning as those in the Privacy Rule.

16. Interpretation

Any ambiguity in this Exhibit shall be resolved to permit County to comply with the Privacy Rule and Security Rule.

Appendix 8 ~ Sample MOU Between PHFE WIC and a Health Plan

Category	Responsibility of WIC	Responsibility of PLAN
Liaison	WIC Program Director will coordinate activities with PLAN and notify WIC staff of their roles and responsibilities.	PLAN'S (<i>insert title</i>) will coordinate activities with WIC and notify staff and participating providers of their roles and responsibilities.
	WIC Program Director will meet with Public Health Programs Administrator as needed to communicate and to resolve operational, administrative and policy issues.	PLAN'S (<i>insert title</i>) will meet with WIC Program Director as needed to communicate and to resolve operational, administrative and policy issues.
Provider Network	Act as a consultant to PLAN and participating providers updating WIC policies and guidelines, as necessary.	Inform PLAN's participating providers/staff of the federal WIC eligibility requirements and of their responsibilities to enrollees of the WIC program.
	Provide information to PLAN on WIC program services and federal regulations for PLAN staff and participating providers, as requested.	Inform PLAN's staff and participating PCPs of WIC Program services and federal regulations, with consultation from the WIC staff.
	Distribute WIC referral forms CDPH 247A to participating providers.	

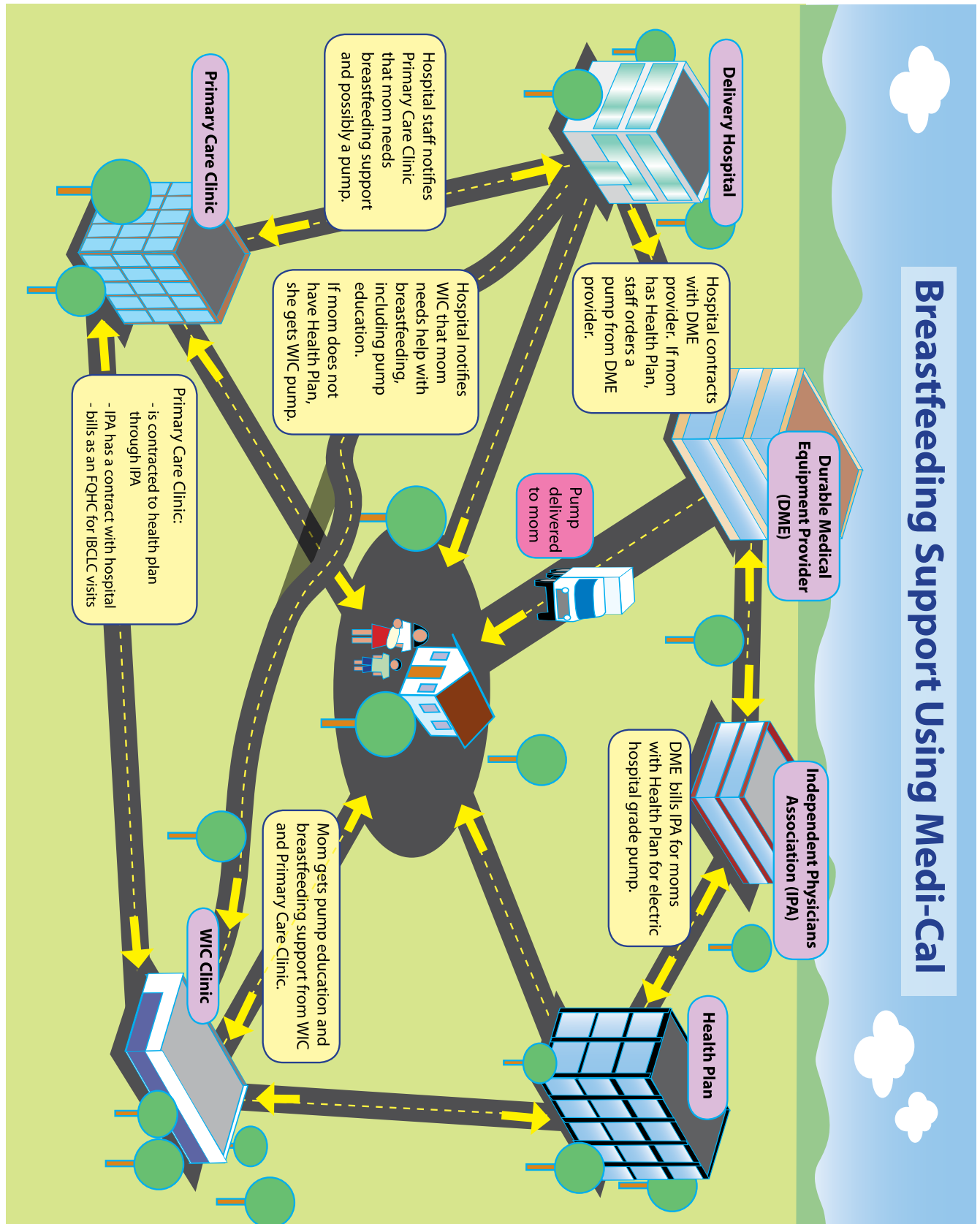
Category	Responsibility of WIC	Responsibility of PLAN
Client Referral and Outreach	Refer WIC participants who are income eligible for Medi-Cal to the WIC Department of Human Assistance for assistance in choosing a PLAN and PCP.	Inform PLAN's Members of the availability of WIC services including nutrition education, supplemental food and community referrals.
	Provide PLAN with WIC telephone number for client applications and appointments.	<p>Participating PCPs will refer Members who are pregnant, breastfeeding or postpartum women, or parents of children under five years of age, to the WIC Program. A "referral" consists of the following:</p> <ol style="list-style-type: none"> 1. Perform Hgb or Hct tests and height/weight measurement and document on one of the following: <ol style="list-style-type: none"> a. WIC referral form CDPH 247A b. Physician prescription pad c. CHDP screening/billing report form PM 160 2. Document diagnosed clinical conditions and sign and dates the referral form. Give the form to the patient for delivery to the WIC Program. 3. Briefly explain the WIC Program to Members and provide them with the WIC program telephone number.
	Share information with PLAN and participating providers about making referrals to appropriate community resources and agencies.	Coordinate with WIC in conducting outreach efforts, especially to underserved populations
	Coordinate with PLAN in conducting outreach efforts to enrollees not using preventative health services.	

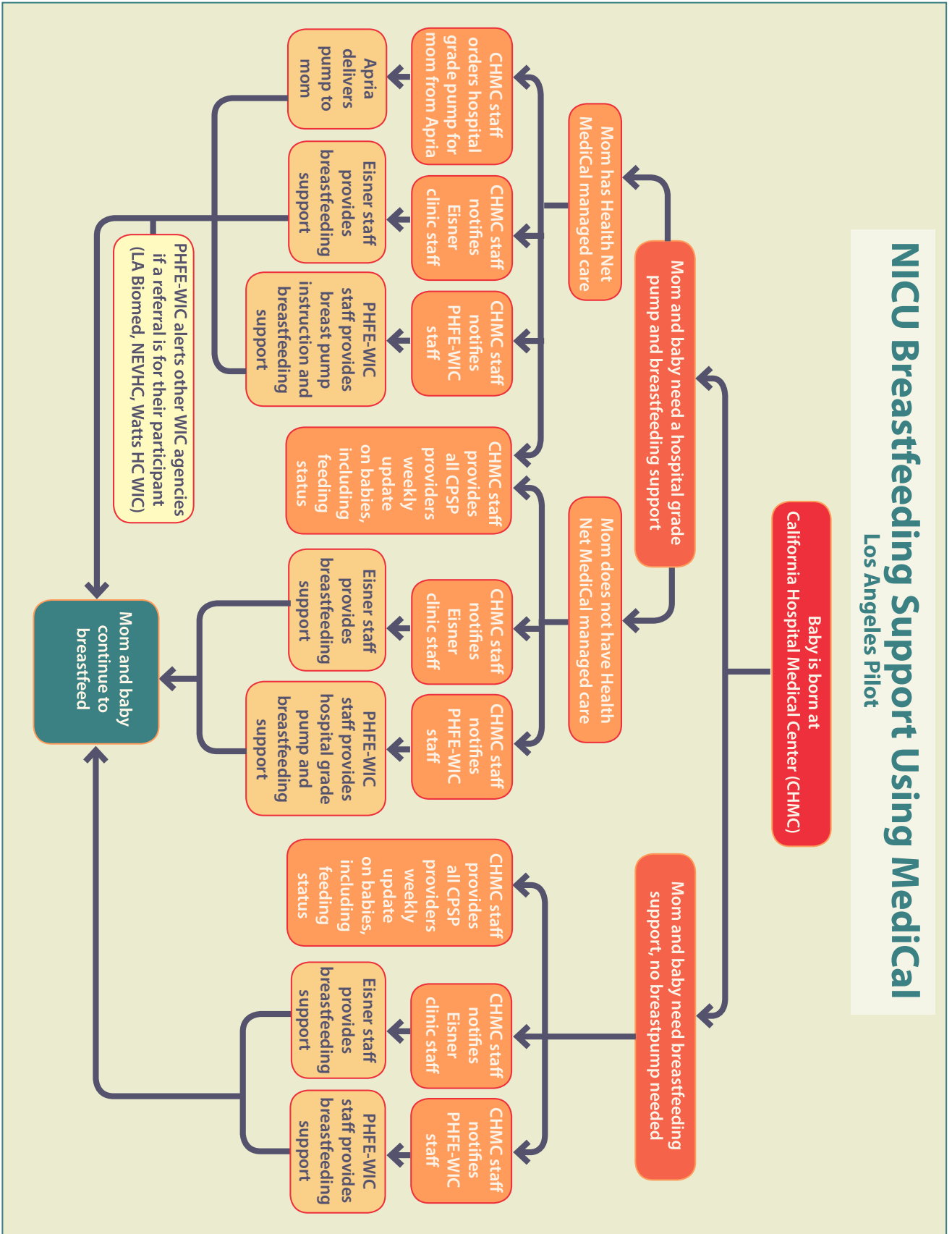
Category	Responsibility of WIC	Responsibility of PLAN
Appointment Scheduling	<p>Upon telephone contact by Member to WIC Program, explain the medical data and other documentation required at first appointment in order to enroll in program. Send forms necessary for WIC Program enrollment via mail.</p>	
	<p>Schedule a WIC appointment to determine eligibility for pregnant women and migrant family members within 10 calendar days after initial contact by Member. All other applicants will be scheduled and notified of their eligibility or ineligibility within 20 calendar days of the date of the first request for program benefits.</p>	

Category	Responsibility of WIC	Responsibility of PLAN
Health Requirements	Inform PLAN of federal WIC requirements for program participation.	Inform PLAN’s participating providers of federal WIC requirements for program participation: <ol style="list-style-type: none"> A. Biochemical: <ol style="list-style-type: none"> 1. Hemoglobin (Hgb) or hematocrit (Hct) presented within 90 days of enrollment and within 90 days of each succeeding 6 month certification <u>except for</u>: <ul style="list-style-type: none"> • Child whose blood value was within normal limits at the previous certification. For these children the Hgb/Hct test is required every 12 months 2. Infants under 9 months of age B. Anthropometric: height/length and weight current, dated within 60 days for enrollment and with each 6-month re-certification.
	<p>Review eligibility for WIC Program services every six months: assess income and nutritional status (including current height and weight).</p> <p>Review hemoglobin or hematocrit value once a year (exception: children with anemia [Hgb less than 11.0 g/dl or Hct less than 33%] must have blood values reviewed every six months).</p>	Implement procedures to require that PLAN’s participating providers document WIC referral in medical record of PLAN Member and provide reasonable follow-up to WIC referrals.

Category	Responsibility of WIC	Responsibility of PLAN
Breastfeeding Promotion and Support	Provide education and encourage all prenatal WIC participants to breastfeed as the preferred method of infant feeding in the first year of life, consistent with World Health Organization (WHO) recommendations for a breastfeeding friendly environment.	Collaborate with WIC to provide education to participating providers and prenatal and breastfeeding Members on the benefits of breastfeeding in the first year of life.
	Work collaboratively with PLAN to: <ul style="list-style-type: none"> • Provide training to participating PCPs on breastfeeding promotion and support. • Support efforts of participating PCPs and contracted hospitals to promote breastfeeding. 	Work collaboratively with WIC to: <ul style="list-style-type: none"> • Support the efforts of PLAN participating providers and hospitals to promote breastfeeding. • Encourage PLAN participating providers to create a positive clinic environment that endorses breastfeeding as the preferred method of infant feeding. • Refer postpartum patients to WIC lactation services. • Refrain from distributing infant formula samples and materials promoting infant formula.
	Provide WIC participants with appropriate breastfeeding education materials.	
	Create a positive clinic environment that endorses breastfeeding as the preferred method of infant feeding.	
	Provide breastfeeding support services for WIC clients within 24 hours of the identification of a breastfeeding problem.	
	Refer Members back to PCP who are in need of lactation medical durable equipment.	

Category	Responsibility of WIC	Responsibility of PLAN
Nutrition Assessment and Education	Provide the following at the first WIC appointment: <ol style="list-style-type: none"> 1. Determine the nutritional risk(s) for WIC Program eligibility and recertification based on review of anthropometric, biochemical, clinical, medical and/or dietary information. 	Require that PLAN'S participating providers document nutritional risks and medical necessity for WIC services. Require that PLAN'S participating providers document medical necessity for WIC to provide standard infant formulas that are not under the current WIC infant formula contract. PLAN will provide medically necessary formulas that are not provided by WIC.
	<ol style="list-style-type: none"> 2. Develop and document a goal for health improvement that is participant selected. 3. Provide basic nutrition education and services including supplemental food prescription. 4. For high-risk conditions, provide <i>basic</i> nutrition counseling by WIC Registered Dietician. Refer to PLAN for <i>medical nutrition therapy</i> services. 	Arrange for the provision of medical nutrition therapy services for high-risk conditions (e.g. nutrition care plan for control of diabetes or hypertension.)





Appendix 11 ~ Hospital Breastfeeding Referral Form



NICU BREAST PUMP PILOT PROGRAM
For Medi-Cal Manged Care with Health Net

Starting June 1st, 2010

For Patients with Health Net Medi-Cal ONLY
(For all other WIC participants follow standard protocol)
Please follow the following procedure until further notice

STEP ONE:

1. Obtain a physician order for a breast pump
(Order should be marked "STAT" so that the pump is delivered within 24hrs of mother's discharge)
2. Obtain mother's consent for disclosing PHI information
FAX the order & a facesheet (with updated phone & address) to APRIA HEALTHCARE (information on fax cover sheet)

STEP TWO:

1. Obtain Consent for disclosing PHI information
Fill out & FAX WIC Referral form (Mark that mother will receive Apria pump)
2. Mothers with Health Net Medi-Cal Insurance will receive a hospital-grade pump through our DME provider & the WIC program will provide follow-up support & education for pump use.

****You can easily identify patients with Health Net Medi-Cal Insurance Directly from their face-sheet**

INSURANCE	1. PRIMARY INSURANCE	HEALTH NET MCAL CAP	CODE	2503	
	MEDICAL GROUP	HEALTH NET MCAL CAP	CODE	02503	
	STREET ADDRESS ENCOUNTER DATA				
	CITY STATE, ZIP				
	GROUP NO.	MEDICARE/MEDI-CAL 912345678A101112			
	SUBSCRIBER Happy Mother				
	PATIENT RELATIONSHIP TO SUBSCRIBER	SELF	SUBSCRIBERS DOB	AUTH. #	
	MAIL CLAIM TO STREET ADDRESS ENCOUNTER DATA				
	CITY STATE, ZIP				

For more information please contact: Lily Morales @ 213-742-6421

Appendix 12 ~ Hospital Breast Pump Referral Form

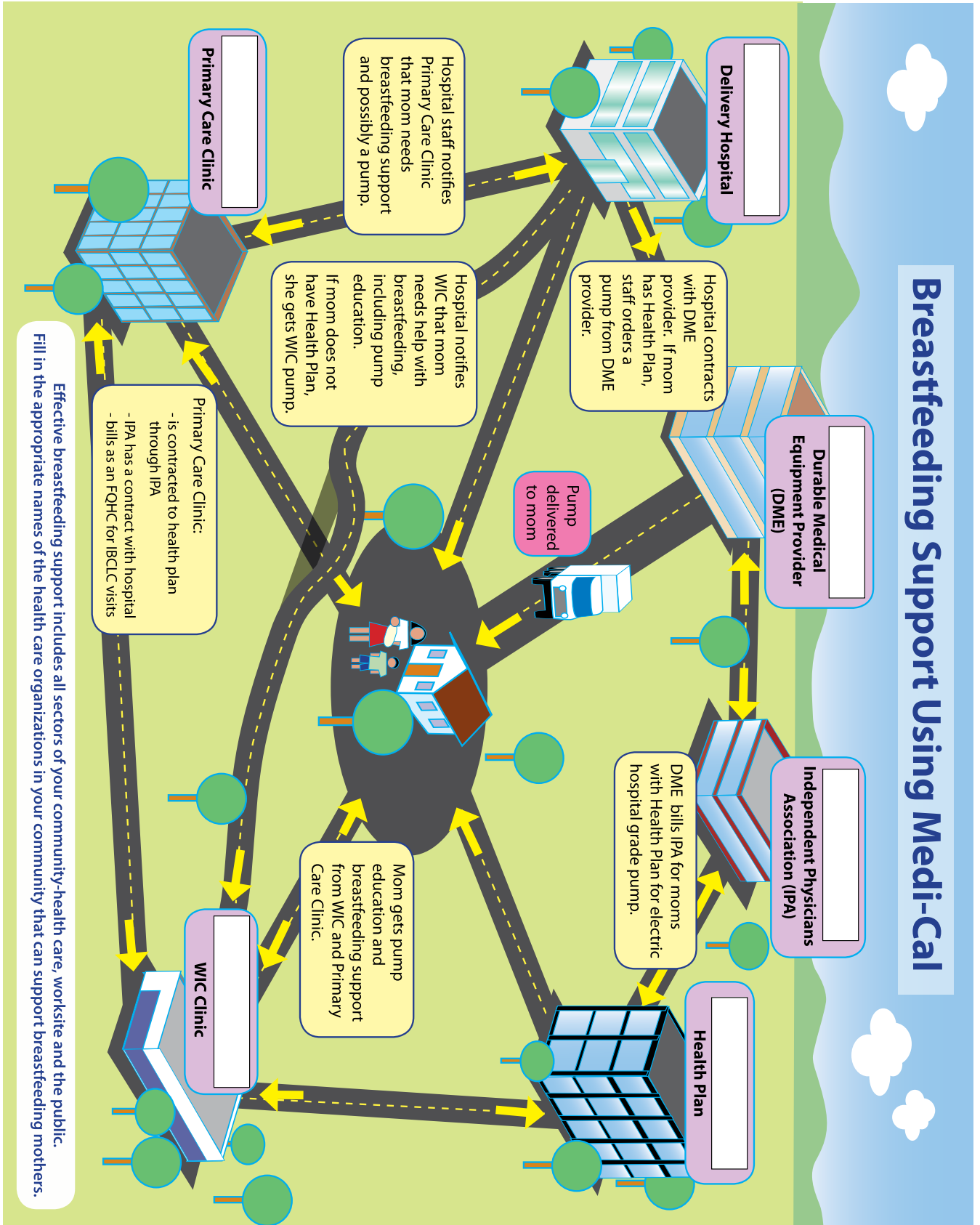
Department & Department Ext:		Referred By:
Referral To: (who is providing breast pump)	Apria – electric breast pump (If Apria please check both) WIC- Breastfeeding Support and/ or breast pump instruction	WIC (check all that apply) Electric Breast Pump Breastfeeding Support
WIC Center:		
Mother’s Name:		
Infant’s Name:		
Date of Birth:		
Gestational Age:		
Discharge Date:		
Language:		
Phone Number:		
Address:		
Other Information/ Reason for Referral:		

For ALL Apria requests: Fax to Apria at 866-228-1290 and PHFE-WIC Main Office Breastfeeding Support Line at 626-208-1338.

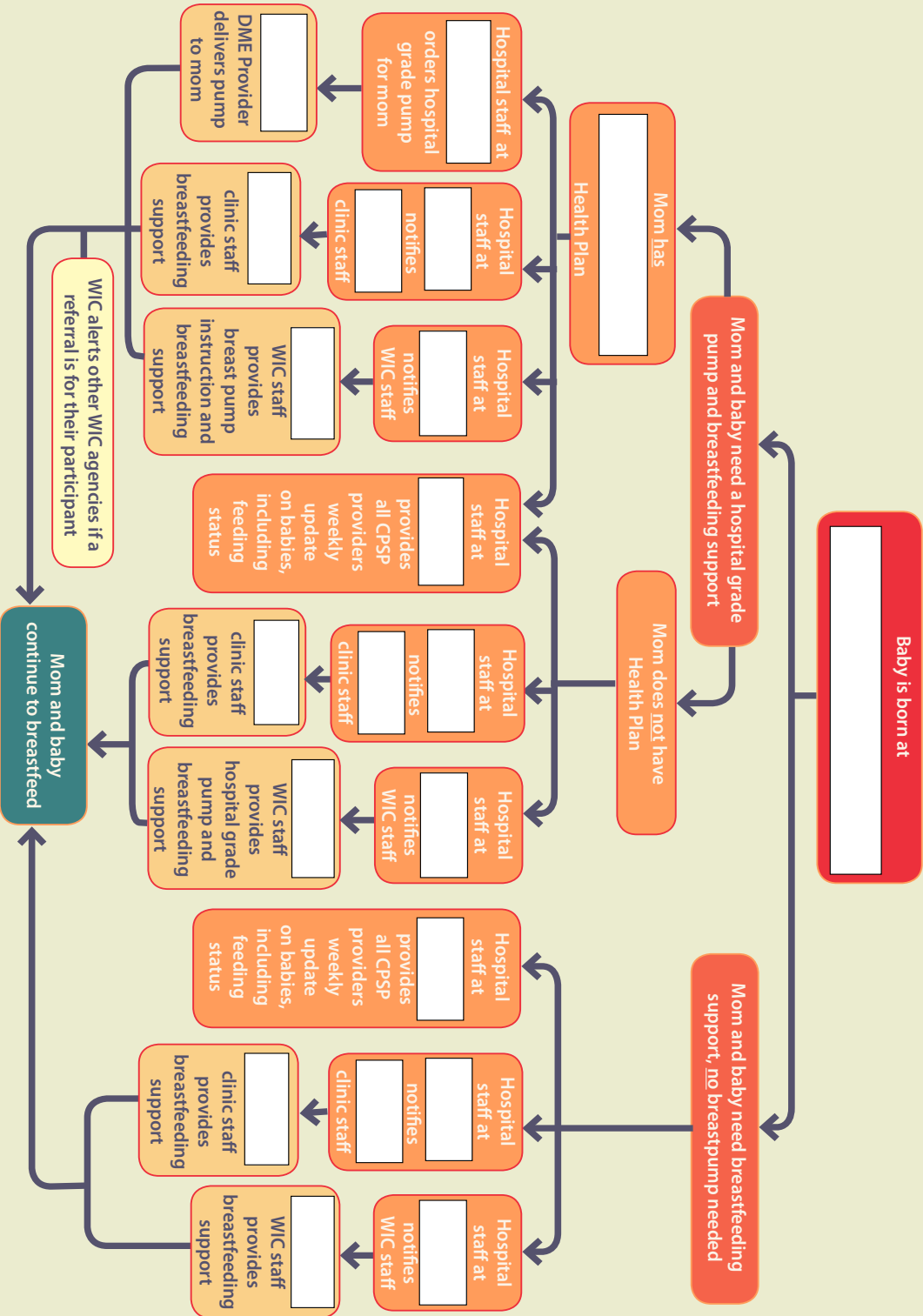
For ALL WIC requests: Fax to PHFE-WIC Main Office Breastfeeding Support Line at 626-208-1338

Please note that Pediatrician’s office will receive weekly NICU updates.

Breastfeeding Support Using Medi-Cal



Shared Support for Building a Sustainable and Effective Breastfeeding Network



Effective breastfeeding support includes all sectors of your community—health care, worksite and the public. Fill in the appropriate names of the health care organizations in your community that can support breastfeeding mothers.

Glossary of Terms Related to Billing for Lactation Services

ACA Affordable Care Act

A federal statute signed into law in March 2010 as part of health care reform. The law includes multiple provisions that will take effect over a matter of years, including expansion of Medicaid eligibility, establishment of health insurance exchanges, and prohibition of health insurers from denying coverage due to pre-existing conditions. <http://www.whitehouse.gov/healthreform/healthcare-overview>; www.healthcare.gov

Baby Friendly Hospital

A global program sponsored by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding. <http://www.babyfriendlyusa.org>

Clinical Preventive Services

Screening, counseling, immunizations, or medications used to prevent disease, detect health problems early, or provide the information people need to make good decisions about their health. <http://www.healthcare.gov/prevention/nphpphc/strategy/preventive-services.pdf>

CPHW Comprehensive Perinatal Health Workers

Subset of Medi-Cal practitioners that provides medical and support services to pregnant women.

CPSP Comprehensive Perinatal Services Program

A Medi-Cal program that provides a model of comprehensive services for eligible low-income pregnant and parenting women. <http://www.cdph.ca.gov/programs/CPSP/Pages/default.aspx>

DME Durable Medical Equipment

Any medical equipment used in the home to aid in a better quality of life.

DPA Dual Provider Agreement

An agreement set up between the CPSP agency seeing the client and the CPSP site the client came from.

Essential Health Benefits

A set of health care service categories that must be covered by certain plans. Categories include, among others, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services.

FQHC Federally Qualified Health Center

A benefit under Medicare in which community-based organizations provide primary care and preventive care to persons of all ages, regardless of ability to pay.

<https://www.cms.gov/center/fqhc.asp>

HE Health Educator

An individual who informs and trains patients on health-related topics.

IBCLC International Board Certified Lactation Consultant

A credential that identifies a knowledgeable and experienced member of the maternal-child health team who has specialized skills in breastfeeding management and care.

<http://www.iblce.org/>

IPA Independent Physician Association

An independent group of physicians and other health-care providers who are under contract to provide services to managed care organizations for a negotiated or flat fee.

Medi-Cal

The California implementation of Medicaid, a public health insurance program that provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, foster care, pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS.

<http://www.dhcs.ca.gov/services/medi-cal/pages/default.aspx>

Medi-Cal Practitioner

One who works within a Medi-Cal Provider to provide medical and support services for those qualified in the Medi-Cal program.

Medi-Cal Provider Bulletin

Resources and supplemental information provided by the Department of Health Care Services and the California Department of Public Health.

http://files.medi-cal.ca.gov/pubsdoco/bulletins_menu.asp

Medi-Cal Provider

Any individual or group that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.

MOU Memorandum of Understanding

A document describing a bilateral/multilateral agreement between parties that expresses an intended common line of action.

PPO Preferred Provider Organization

Network of medical providers who charge on a fee-for-service basis but are paid on a negotiated, discounted fee schedule.

RD Registered Dietitian

A health care professional who focuses on proper food and nutrition to promote good health.

TAR Treatment Authorization Request

The form used by providers to request authorization from Medi-Cal in order for Medi-Cal to reimburse for health care services to Medi-Cal recipients.

<http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx>

WIC Women, Infants and Children Supplemental Nutrition Program

The Special Supplemental Nutrition Program for Women, Infants, and Children.

A 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) women and children up to the age of five.

Sources of simplified definitions:

ACA <http://www.investopedia.com/terms/a/affordable-care-act.asp#axzz1cTGStTu>

CPSP <http://cchealth.org/services/perinatal/>

FQHC <https://www.cms.gov/mlnproducts/downloads/fqhcfactsheet.pdf>

PPO <http://www.ambest.com/resource/glossary.html#P>

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