Affordable Care Act

The Affordable Care Act (ACA) has two major provisions affecting breastfeeding - (1) coverage of comprehensive lactation support and counseling and (2) costs of renting or purchasing breastfeeding equipment for the duration of breastfeeding.

These provisions, however, are typically linked to maternal benefits under the insurance plans and therefore coverage may be dependent upon submitting claims under the mother’s name. If pediatric providers plan to provide these services and expect the claims to be adjudicated with benefits covered under ACA provisions, the claim may have to be submitted under the mother’s name and not the baby’s. Check with your payers under the essential health benefits for more details. Remember that services provided out of a payer’s network can be subject to cost sharing.

Below is a link to a Section on Breastfeeding resource on ACA provisions and federal support for breastfeeding. Also the section has developed a letter for payers.

FEDERAL SUPPORT FOR BREASTFEEDING

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 current ICD-9-CM codes.
- 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.
- A new patient is one who has not received any professional face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

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 fact discusses:

1. Options for billing the three-to-five day visit
2. Billing for extra time spent at well baby visits
3. Use of time-based coding
4. Billing for consults
5. Billing for care provided for the mother
6. Billing for allied health professional services
7. Commonly reported ICD-9-CM (for use before Oct 1, 2014) and ICD-10-CM codes (for use on or after Oct 1, 2015)
8. Codes for breast pump

*Unless restricted by their state or payers’ 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.

The three-to-five day visit

The AAP recommends 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** V20.32 (and any other indicated diagnosis codes, eg, 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.

**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.

- The earlier chart must document the unresolved problem that requires a follow-up visit.
- An appropriate diagnosis code, e.g., “newborn feeding problem” (779.31), 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 779.31, 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)
Both visits are then reported, appending the modifier 25 to the problem-based visit code. For example, using an established patient 8 to 28 days old, you would report:

99391 V20.32

99212 25 779.31

Note: Some payers do not pay for both E/M services on the same date.

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, eg, 99212–99215, when counseling, education, or coordination of care dominate a visit otherwise not meeting customary guidelines for history, physical, and medical decision-making. (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”). Also note that typical times are not threshold times and you do not need to reach the time listed in a specific code in order to report it, but must be closer to that time, then the time listed in the code below.

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

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

[For example, if you spent 35 minutes face to face with an established baby and mother, of which greater than 18 minutes were spent counseling about feeding issues, you could bill with CPT code 99215, ignoring the usual history, exam, and medical decision-making requirements for a 99215. Since 35 minutes is closer to 40 minutes (99215) rather than 25 minutes (99214), you would report a 99215. 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 and the original request is to gather your advice or opinion. This cannot be a transfer of care.

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 payer 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. Remember under the ACA provisions, in order to not incur cost sharing, these services may need to be submitted under the mom and not the baby.

- 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, a qualified nonphysician health care professional may see the patient to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems. The focus in on the biopsychosocial factors important to physical health problems, and treatments (the AMA’s CPT manual, 2014 page 591). 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:

<table>
<thead>
<tr>
<th>Medical Discussion in minutes</th>
<th>Physician Calls</th>
<th>Non-physician Provider Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10 minutes</td>
<td>99441</td>
<td>98966</td>
</tr>
<tr>
<td>11-20 minutes</td>
<td>99442</td>
<td>98967</td>
</tr>
<tr>
<td>21-30 minutes</td>
<td>99443</td>
<td>98968</td>
</tr>
</tbody>
</table>

**Online Medical Evaluations**

E/M services
- provided to an established patient, or guardian
- 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
- To bill for codes 99366-99368 there must be a minimum of 3 qualified health care professionals in attendance

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# Codes for Breast Pumps

**HCPCS Codes**
- E0602 - Breast pump, manual, any type
- E0603 - Breast pump, electric (AC and/or DC), any type
- E0604 - Breast pump, hospital grade, electric (AC and/or DC) any type

## Commonly Reported *Diagnosis* Codes

### Baby

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding problems/ slow feeding, newborn</td>
<td>779.31</td>
</tr>
<tr>
<td>Bilious vomiting in newborn</td>
<td>779.32</td>
</tr>
<tr>
<td>Other vomiting in newborn</td>
<td>779.33</td>
</tr>
<tr>
<td>Feeding problem, infant (&gt; 28 days)</td>
<td>783.3</td>
</tr>
<tr>
<td>Vomiting, infant (&gt;28 days)</td>
<td>787.03</td>
</tr>
</tbody>
</table>

### Jaundice

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastmilk jaundice</td>
<td>774.39</td>
</tr>
<tr>
<td>Neonatal jaundice, unspecified</td>
<td>774.6</td>
</tr>
<tr>
<td>Preterm jaundice</td>
<td>774.2</td>
</tr>
</tbody>
</table>

### Weight and hydration

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dehydration, neonatal</td>
<td>775.5</td>
</tr>
<tr>
<td>Failure to thrive, newborn</td>
<td>779.34</td>
</tr>
<tr>
<td>Weight loss</td>
<td>783.21</td>
</tr>
<tr>
<td>Underweight</td>
<td>783.22</td>
</tr>
<tr>
<td>Slow weight gain, FTT, infant (&gt;28 days)</td>
<td>783.41</td>
</tr>
<tr>
<td>Abnormal weight gain</td>
<td>783.1</td>
</tr>
</tbody>
</table>

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

### Infant distress

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fussy infant/baby</td>
<td>780.91</td>
</tr>
<tr>
<td>Excessive crying, infant</td>
<td>780.92</td>
</tr>
<tr>
<td>Infantile colic or intestinal distress</td>
<td>789.7</td>
</tr>
</tbody>
</table>

### GI issues

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal stools</td>
<td>787.7</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>787.91</td>
</tr>
<tr>
<td>Change in bowel habits</td>
<td>787.99</td>
</tr>
</tbody>
</table>

### Mouth

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankyloglossia</td>
<td>750.0</td>
</tr>
<tr>
<td>High arched palate</td>
<td>750.26</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other specified follow-up exam</td>
<td>V67.59</td>
</tr>
</tbody>
</table>

*^ICD-9-CM Codes 630 – 679 are only for use on the maternal record*

### Mother

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast &amp; Nipple issues</td>
<td></td>
</tr>
<tr>
<td>Breasts, breast / Mastitis, infective</td>
<td>675.14</td>
</tr>
<tr>
<td>Blocked milk duct / Mastitis, interstitial</td>
<td>675.24</td>
</tr>
<tr>
<td>Breast engorgement, ductal</td>
<td>676.24</td>
</tr>
<tr>
<td>Burning pains, hyperesthesia</td>
<td>782.0</td>
</tr>
<tr>
<td>Ectopic or axillary breast tissue</td>
<td>757.6</td>
</tr>
<tr>
<td>Galactocele</td>
<td>676.84</td>
</tr>
<tr>
<td>Other specified nipple/breast anomaly</td>
<td>757.6</td>
</tr>
<tr>
<td>Other specified nipple/breast infection</td>
<td>675.84</td>
</tr>
<tr>
<td>Nipple infection</td>
<td>675.04</td>
</tr>
<tr>
<td>Nipple, cracks or fissures</td>
<td>676.14</td>
</tr>
<tr>
<td>Nipple, sore</td>
<td>676.34</td>
</tr>
<tr>
<td>Retracted nipple, postpartum</td>
<td>676.04</td>
</tr>
<tr>
<td>Impetigo (staph), nipple</td>
<td>684</td>
</tr>
<tr>
<td>Candidiasis, nipple or breast</td>
<td>112.89</td>
</tr>
</tbody>
</table>

### Constitutional

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disrupted sleep cycle</td>
<td>780.55</td>
</tr>
<tr>
<td>Fatigue</td>
<td>780.79</td>
</tr>
</tbody>
</table>

### Lactation

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agalactia, failure to lactate</td>
<td>676.44</td>
</tr>
<tr>
<td>Lactation, delayed</td>
<td>676.84</td>
</tr>
<tr>
<td>Lactation, suppressed</td>
<td>676.54</td>
</tr>
<tr>
<td>Other specified disorders of lactation</td>
<td>676.84</td>
</tr>
<tr>
<td>Supervision of lactation</td>
<td>V24.1</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other specified follow-up exam</td>
<td>V67.59</td>
</tr>
</tbody>
</table>

*^When the original reason for visit has resolved*

Report *ICD-9-CM* codes through September 30, 2015
Feeding problems
ICD-10-CM*

P92.01 Bilious vomiting of newborn
P92.09 Other vomiting of newborn
P92.1 Regurgitation and rumination of newborn
P92.2 Slow feeding of newborn
P92.3 Underfeeding of newborn
P92.5 Neonatal difficulty in feeding at breast
P92.8 Other feeding problems of newborn
P92.9 Feeding problem of newborn, unspecified
R11.10 Vomiting, unspecified (>28 days old)
R11.12 Projectile vomiting (>28 days old)
R11.14 Bilious vomiting (>28 days old)

Jaundice
P59.0 Neonatal jaundice associated with preterm delivery
P59.3 Neonatal jaundice from breast milk inhibitor
P59.8 Neonatal jaundice from other specified causes
P59.9 Neonatal jaundice, unspecified

Weight and hydration
P74.1 Dehydration of newborn
P74.2 Disturbances of sodium balance of newborn
P74.3 Disturbances of potassium balance of newborn
P92.6 Failure to thrive in newborn
R62.51 Failure to thrive in child over 28 days old
R63.4 Abnormal weight loss
R63.5 Abnormal weight gain
R63.6 Underweight

Infant distress
R68.11 Excessive crying of infant (baby)
R68.12 Fussy infant (baby)
R10.83 Colic

GI issues
R19.4 Change in bowel habit
R19.5 Other fecal abnormalities
R19.7 Diarrhea, unspecified
R19.8 Other specified symptoms and signs involving the digestive system and abdomen

Mouth
Q38.1 Ankyloglossia
Q38.5 Congenital malformations of palate (high arched palate)

Other
Z09 Encounter for follow-up examination after completed treatment
(When the original reason for visit has resolved)

Mother*
ICD-10-CM*

Breast & Nipple issues
B37.89 Candidiasis, breast or nipple
L01.00 Impetigo, unspecified
O91.02 Infection of nipple associated with the puerperium
O91.03 Infection of nipple associated with lactation
O91.13 Abscess of breast associated with lactation/Mastitis purulent
O91.23 Nonpurulent mastitis associated with lactation
O92.03 Retracted nipple associated with lactation
O92.13 Cracked nipple associated with lactation
Q83.8 Other congenital malformations of breast (ectopic or axillary breast tissue)
R20.3 Hyperesthesia (burning)

Constitutional
G47.23 Circadian rhythm sleep disorder, irregular sleep wake type
G47.9 Sleep disorder, unspecified
R53.83 Fatigue

Lactation
O92.3 Agalactia
O92.4 Hypogalactia
O92.5 Suppressed lactation
O92.6 Galactorrhea
O92.70 Unspecified disorders of lactation
O92.79 Galactoceles (Other disorders of lactation)
Z39.1 Encounter for care and examination of lactating mother
(Excludes encounter for conditions related to O92.-)

Other
Z09 Encounter for follow-up examination after completed treatment
(When the original reason for visit has resolved)

^Do not use any codes listed under the mother for the baby’s medical record

*Report ICD-10-CM codes for services on or after October 1, 2015