TIPS FOR GETTING REIMBURSED BY ANTHEM FOR LACTATION CARE

From Serena Meyer of Bay Area Breastfeeding Support, 3/2/19:

If you are having problems breastfeeding did you know that your insurance HAS to pay for lactation care? Its mandated coverage as preventive health care and you are entitled to it.

Certain insurance covers certain codes but they all have to cover part of it.

1. Call Anthem's member phone number and ask for a list of in-network lactation consultants in your area. They may give you the run-around or turn it around on you and ask YOU to provide THEM the names of the consultants you want to see -- only to tell you that those consultants are not in-network. If they do this, insist again that they provide a list of in-network lactation consultants. If they try to give you the run-around again, insist yet again that they provide a list of in-network lactation consultants and, if they can't, make sure they clearly tell you that they can't.

2. If they can't provide you a list of in-network lactation consultants within a 75-mile radius of where you live, you are entitled to open an in-for-out case. This allows you to get your out-of-network claims processed at the in-network level, so you would only be responsible for the total beyond the in-network total allowed. These cases are handled by a nurse case manager on your insurance company's medical management team. You call the same member phone number but you choose the option for pre-approval or pre-certification and ask to make an in-for-out request.

3. WARNING: The wait for this particular team is LONG. It can be over an hour before someone picks up. So when you call, be ready with all of the information you need because you don't want to waste your time. You'll need: the CPT/procedure and diagnosis codes that would be used during your visits; your phone number; your full name and date of birth; your baby's name and date of birth; your home address; how many visits you are seeking and which codes your consultant will use for each visit; your consultant's name; your consultant's business's name; your consultant's NPI number; and your consultant's EIN number. You may also need to tell them whether the visits will be at your home or at your consultant's office. IMPORTANT: Make sure the person opens your case in YOUR name and not your baby's. Also make sure the case includes a date range that will cover ALL of your visits. The representative will give you a reference case number and a fax number that your consultant will use to send what they call a clinical.

Here is the info they will ask you for:

CPT codes:

99204 for an initial consult and 99404 for preventive health teaching at the same time
99214 for a follow up and 99404 for preventive health teaching at the same time

ICD10 code: Z39.1, care of the lactating mother
Modifier codes: v33 and v25

	Serena Meyer	**Amanda Halpin**
Business Name	Bay Area Breastfeeding Support	Halpin Lactation Care
NPI	1306113881	1972875706
EIN	45-3915267	83-1708553
CA RN license	95048954	733976
CA NP license	n/a	21023
IBCLC number	1113721	Exam April 2019
Phone number	925-257-4023	650-488-1524
Fax number	510- 275-0331	650-963-5731
Email	eastbaylc@gmail.com	amanda@halpinlactation.com

4. As soon as you have the reference case number, ask your consultant to send a “clinical” to your insurance company with your reference case number on the cover letter. Nothing else should be on the cover letter, especially no personal health information. The clinical should outline what your plan for treatment is. The nurse reviewing your case will use the clinical to make a determination.

5. The nurse has 15 calendar days from the time a clinical is received to respond to you. They'll likely call with a determination, but they'll follow up with a letter. In my experience, calling every day to check in on the case doesn't help or speed up the time of a response.

6. Once you've been approved, schedule your visits. You'll need to pay for the visits up front. Before your visits, ask your insurance company which claim form you must submit for reimbursement. Print out the claim form and bring it to your visit so you and your consultant can fill it out together. Submit your claim form to request reimbursement as soon as your visit is over. Your insurance company may allow you to submit it electronically via a member portal. That will save you the time of sending it via snail mail.

Other tips: Write down the name of EVERY person you speak to about your case. That way, there is always a trail and someone held accountable. This will come in handy countless times, I

PROMISE. Keep track of every conversation you have related to your case and document exactly what was said and what information you provided during each one. Lastly, be aggressive and don't give up -- because that's what they're hoping you'll do. It's not nearly as difficult as it sounds to track down all the information you need. It just sounds difficult because of the alphabet soup they drown you in. Keep your head up and persevere!!

Additional resources:

California Network Adequacy standards
https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf

MEDICAID MANAGED CARE FINAL RULE: NETWORK ADEQUACY STANDARDS

1. Executive Summary

The Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) establishes network adequacy standards in Medicaid and CHIP managed care for certain providers and provides flexibility to states to set state specific standards. California currently has network adequacy standards in place that meet many of these requirements. The State also maintains network adequacy standards/requirements that exceed those that are required in the Final Rule.

This document outlines California's network standards in response to meeting compliance with the network adequacy provisions of the Final Rule. These federal requirements are described in Section 2.1, Federal Medicaid and CHIP Managed Care Final Rule and incorporated in Attachment B of the Appendix.

Section 4, Final Network Adequacy Standards, of this document describes the approach to determining and reasoning for California's standards. DHCS will be responsible for monitoring compliance with the standards described in this document.

Table 1. California's Final Network Standards

Provider Type	Time and Distance	Timely Access for Non-Urgent[1] Appointments
Primary Care (adult and pediatric)	10 miles or 30 minutes from the beneficiary's residence	Within 10 business days to appointment from request
Specialty Care (adult and pediatric)	Based on county population size as follows: *Rural Counties*: 60 miles or 90 minutes from the beneficiary's residence *Small Counties*: 45 miles or 75 minutes from the beneficiary's residence *Medium Counties*: 30 miles or 60 minutes from the beneficiary's residence *Large Counties*: 15 miles or 30 minutes from the beneficiary's residence	Within 15 business days to appointment from request

Attachment E
California Counties by Size

Size Category	Population	# of Counties	Counties
Rural	<55,000 to 199,999	30	Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
Small	200,000 to 999,999	19	Butte, Fresno, Kern, Marin, Merced, Monterey, Placer, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo
Medium	1,000,000 to 3,999,999	8	Alameda, Contra Costa, Orange, Riverside, Sacramento, San Bernardino, San Diego, Santa Clara
Large	≥ 4,000,000	1	Los Angeles

Anthem CA Member Claim Form:
https://www.anthem.com/docs/24066CAMENABC.pdf

National Women's Law Center Toolkit
New Benefits for Breastfeeding Moms:
Facts and Tools to Understand Your Coverage under the Health Care Law
Sample appeal letter for lactation coverage on page 11.
https://www.nwlc.org/sites/default/files/pdfs/final_nwlcbreastfeedingtoolkit2014_edit.pdf?fbclid=IwAR0eRLpFAbeJUaSJwaiOvz9Npg8Y8suTIMTsKjzkqQFA2zUAAaffeQhoLjg