Medical Necessity Guidelines:
Breast Pumps for Tufts Health RITogether

Effective: June 17, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☐Tufts Health Plan Commercial products; Fax: 617.972.9409
☐Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☐Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☐Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) **–** Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

A breast pump is a device used to extract milk from the breast of a lactating mother for infant feeding. There are three types of breast pumps. These are manual, electric, and hospital grade electric pumps.

CLINICAL COVERAGE CRITERIA

Manual Breast Pumps:
- **Prior authorization is not** required
- Tufts Health Plan will cover the purchase of one manual breast pump for pregnant or postpartum Members per pregnancy
- The pump must be obtained from a contracting Durable Medical Equipment (DME) provider
- The Member must have a physician's prescription

Electric Breast Pumps

Tufts Health Plan may cover an electric breast pump **without prior authorization** when prescribed by the
ordering provider for one or more of the following indications:
- Newborn in NICU with anticipated extended stay
- Poor infant weight gain, difficult latch/suppressed latch, jaundice
- Failure to establish effective breastfeeding pair
- Mastitis, engorgement, retracted/cracked nipple(s), inadequate milk production
- Mother is required to take medication or have a diagnostic procedure contraindicated with breast feeding and milk must be discarded.

Hospital Grade Breast Pump:

Tufts Health Plan may cover a hospital grade electric breast pump **with prior authorization** when prescribed by the ordering provider once there is prolonged infant hospitalization and one or more of the following:

- Prematurity
- Neurologic disorder
- Genetic abnormality
- Anatomical and mechanical malformation (e.g., cleft lip/ palate); or
- Congenital malformation requiring surgery (e.g., respiratory, cardiac, gastrointestinal, central nervous system)

Note:

- Breast pumps that require prior authorization must include documentation from the ordering provider supporting medical necessity of the item.
- Hospital grade pumps are available as rentals only. Initial authorization shall be up to three months.
- Requests for continued coverage must be documented by the treating provider every three months thereafter confirming medical necessity with a maximum rental period of up to ten months.

CODES

The following CPT/HCPCS code does not require prior authorization:

Table 1: CPT/HCPCS Codes

HCPCS Codes	Description
E0602	Breast pump, manual, any type
E0603	Breast pump, electric (AC and/or DC), any type

The following CPT/HCPCS code(s) require prior authorization:

Table 2: CPT/HCPCS Codes

HCPCS Codes	Description
E0604	Breast pump, hospital grade, electric (AC and/or DC) any type

REFERENCES

1. Executive Office of Health and Human Services, State of Rhode Island. Coverage Guidelines for Durable Medical Equipment. Accessed October 19, 2016. eohhs.ri.gov/Portals/0/Uploads/Documents/breast%20pumps%20final.pdf
2. eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx
3. The Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014.

APPROVAL HISTORY

December 14, 2016: Reviewed by the Integrated Medical Policy Advisory Committee for an effective date of August 1, 2017.

Subsequent endorsement date(s) and changes made:

- July 25, 2018: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes.
- October, 2018: Template and disclaimer updated
- February 20, 2019: reviewed by IMPAC, prior authorization requirement removed for code E0603 effective March 8, 2019.
- July 17, 2019: Reviewed by IMPAC, renewed with no changes
- June 17, 2020: Reviewed by IMPAC, renewed with no changes
- June 26, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in

coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.