Medical Necessity Guidelines: Breast Pumps

Effective: October 11, 2017


Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
 □ Tufts Health Direct — Health Connector; Fax: 888.415.9055
☒ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607
☐ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

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
Breastfeeding is the physiological norm for both mothers and their children. Breast milk offers medical and psychological benefits not available from human milk substitutes. The American Academy of Family Physicians recommends that all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first six months of life1. There are three types of breast pumps. These are manual, electric, and hospital grade electric pumps.

COVERAGE GUIDELINES
I. Consistent with the Patient Protection and Affordable Care Act (PPACA), for Member’s with non-grandfathered plans, prior authorization is NOT required for the following:

Manual and Electric Breast Pumps:
Tufts Health Plan will cover the purchase of one breast pump, either manual or electric, 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

Hospital Grade Electric Breast Pumps:
- Tufts Health Plan will cover the rental of one hospital grade breast pump for postpartum Members, in place of the above, when deemed appropriate by the ordering provider
- The pump must be obtained from a contracting Durable Medical Equipment (DME) provider
- The Member must have a physician’s prescription

A Hospital Grade Breast Pump may be appropriate in the following circumstances:
- Premature hospitalized newborn
- An infant with a congenital anomaly that interferes with the ability to breast feed effectively (e.g., cleft lip, cleft palate, and/or other anomalies of the tongue, mouth or pharynx
- Mother is hospitalized and separated from the newborn/infant

II. For Members whose group plan has maintained grandfathered status under the PPACA prior authorization is required for the following:

Electric or Hospital Grade Breast Pump:
Tufts Health Plan may cover up to two months rental of an electric or hospital grade breast pump in one of the following medically necessary circumstances:
- Hospitalized infant because of prematurity or a medical condition after the Plan Member has been discharged.
- An infant with a congenital anomaly that interferes with the ability to breast feed effectively (e.g., cleft lip, cleft palate, and/or other anomalies of the tongue, mouth or pharynx.
Mother is hospitalized and separated from the newborn/infant

**LIMITATIONS**
- Coverage of breast bumps may vary depending on the terms of the Member's plan benefit document.

**CODES**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>E0602</td>
<td>Breast pump, manual, any type</td>
</tr>
<tr>
<td>E0603</td>
<td>Breast pump, electric (AC and/or DC), any type</td>
</tr>
<tr>
<td>E0604</td>
<td>Breast pump, hospital grade, electric (AC and/or DC), any type</td>
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**REFERENCES**


**APPROVAL HISTORY**

Feb. 11, 2008: Reviewed by the Medical Affairs Medical Policy Committee for effective date of April 1, 2008.

Subsequent endorsement date(s) and changes made:
- July 1, 2008: Coverage guideline requirements clarified
- July 2009: Reviewed, no changes
- August 2011: Admin process changed to RN and LPN
- August 1, 2012: In accordance with PPACA and effective for Members of new groups and non-grandfathered existing groups when they renew on or after August 1, 2012, coverage of the purchase of manual and electric (nonhospital grade) breast pumps added. Guidelines for the coverage of a hospital grade electric breast pump clarified. Grandfathered plan prior authorization coverage clarified
- November 28, 2012: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes. ICD-10 codes will be added prior to the next IMPAC approval.
- October 9, 2013: Reviewed by IMPAC. Prior authorization for groups maintaining grandfathered status clarified on page one. Guidelines for coverage of type of breast pump clarified on page three
- November 19, 2014: Reviewed by IMPAC, renewed without changes
• September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016
• November 16, 2015: Reviewed by IMPAC, renewed without changes
• March 17, 2016: Coding updated; ICD-9-CM codes removed
• November 9, 2016: Reviewed by IMPAC, renewed without changes
• December 14, 2016: Reviewed by IMPAC; format, wording, and clarification changes
• April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
• October 11, 2017: Reviewed by IMPAC, renewed without changes

**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.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. 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. Applicable state or federal mandates or other requirements will take precedence. For CareLinkSM Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines 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.