Medical Necessity Guidelines: Breast Pumps

Effective: March 10, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

<table>
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<tr>
<th>Applies to:</th>
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<tr>
<td>COMMERCIAL Products</td>
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<tr>
<td>☒ Tufts Health Plan Commercial products; Fax: 617.972.9409</td>
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<tr>
<td>• CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</td>
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<tr>
<td>TUFTS HEALTH PUBLIC PLANS Products</td>
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<tr>
<td>☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
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<tr>
<td>☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304</td>
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<td>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</td>
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<td>SENIOR Products</td>
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<td>• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List</td>
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<tr>
<td>• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</td>
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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 durable electric pumps also known as "hospital grade pumps”. Hospital grade breast pumps are considered to be a type of durable medical equipment (DME) and are not designed for commercial sale or use.

CLINICAL COVERAGE CRITERIA
Tufts Health Plan may cover Manual, Electric and Hospital Grade Breast Pumps when medically necessary. The following are required for coverage for any type of Breast Pump:

- The pump must be obtained from a contracting Durable Medical Equipment (DME) provider
- The Member must have a physician’s prescription

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

Hospital Grade Electric Breast Pumps: Tufts Health Plan will cover the rental of one hospital grade breast pump for postpartum Members, in place of a manual or electric pump, when deemed appropriate by the ordering provider. Use of a Hospital Grade Breast Pump may be appropriate in the following circumstances:

- A premature hospitalized newborn/infant
- An infant with a congenital, or other, 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

NOTE: Hospital grade electric breast pump coverage may differ according to plan or products. Please refer to the member’s plan documents and the applicable Preventive Services documents: Tufts Health Plan
## CODES

### Table 1: HCPCS Codes:

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<tr>
<th>HCPCS Code</th>
<th>DESCRIPTION</th>
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<tr>
<td>E0602</td>
<td>Breast pump, manual, any type</td>
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<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
• July 25, 2018: Reviewed by IMPAC, renewed without changes
• October 2018: Template and disclaimer updated
• February 20, 2019: Reviewed by IMPAC, renewed without changes
• July 17, 2019: Reviewed by IMPAC, renewed with no changes
• June 17, 2020: Reviewed by IMPAC, renewed with no changes
• June 24, 2020: Fax number for Unify updated
• June 16, 2021: Reviewed by IMPAC, renewed without changes
• July 20, 2022: Reviewed by MPAC, renewed without changes
• March 10, 2023: Addition of clarifying note regarding coverage per product or plan, addition of link to Preventive list.

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.