

Medical Policy



Breast Pumps and Accessories

▼ Description

A breast pump is a suction device used for withdrawing milk from the breast of a lactating mother for infant feeding when the mother cannot be present at feeding time or when the infant is too sick or weak to suck.

There are three types of pumps available: manual, electric and heavy-duty hospital grade.

- a) Manual pumps are operated by the individual using their hands. Many manual breast pumps use a system of two cylinders to create suction. Once the breast-shield is placed over the nipple and areola, a small cylinder-shaped tube is pumped in and out of a larger cylinder to create a vacuum that expresses milk and collects it in an attached container.
- b) Battery powered and standard electric pumps are powered by either AC or DC current.
- c) Heavy duty hospital grade pumps are electric powered, piston operated, and provide vacuum suction/release cycles with a vacuum regulator.

▼ Policy

For members covered under plans subject to the Patient Protection and Affordable Care Act (PPACA) for coverage of breast pumps, the following are covered when obtained via an in-network provider:

- Standard electric breast pump (non-hospital grade)
 - Coverage is limited to the purchase no more frequently than once per birth.
- Breast pump supplies, including:
 - tubing for breast pump
 - adapter for breast pump
 - cap for breast pump bottle
 - breast shield and splash protector for use with breast pump
 - polycarbonate bottle for use with breast pump
 - locking ring for breast pump

The rental or purchase of a **standard** electric breast pump for plans **not** subject to Patient Protection and Affordable Care Act (PPACA) may be covered when one or more of the following conditions exist:

- The infant is unable to initiate breastfeeding due to a medical condition such as oral defect, cardiac/pulmonary anomalies, etc.
- For multiples or twins until breast feeding at the breast is established consistently
- For premature babies born at 35-36 weeks of gestation when the infant continues to experience difficulty coordinating suck and swallow and the mother is pumping breast milk awaiting the baby's ability to nurse directly from the breast
- For premature babies born at 24-34 weeks of gestation and the mother is pumping breast milk awaiting the baby's ability to nurse directly from the breast
- When the mother has an anatomical breast problem such as inverted nipples or mastitis which may resolve with the use of a breast pump
- When the infant has poor weight gain and pumping breast milk is an intervention in the pediatrician's plan of care
- For any infant who is temporarily unable to nurse directly from the breast such as a baby in NICU or during any hospitalization of the mother or baby that interrupts the ability to nurse
- For mother/infant separation
- When the mother is required to take a medication or undergo a diagnostic test that is contraindicated with breastfeeding

▼ Policy Guidelines

Coverage Criteria:

Documentation must be less than 30 days old and include:

- Diagnosis/medical condition of the infant relating to the need for a breast pump.
- Infants age (gestational age, if premature)
- Mother's discharge date
- Anticipated duration of need.

Associated supplies needed for the operation of the breast pump are included in the rental.

Limitation:

Manual breast pumps are not considered durable medical equipment and are not eligible for coverage.

Hospital grade electric breast pumps for use in the home are not considered reasonable and necessary because they are considered institutional equipment and not appropriate for use in the home.

▼ HCPCS Level II Codes and Description

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

▼ Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

▼References

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- 17)U.S. Food and Drug Administration (FDA). Nonpowered breast pump. Code of federal regulations. Center for Devices and Radiological Health. Revised 2004 Apr 1. Accessed Feb 22, 2005. Available at URL address: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?FR=884.5150>
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Applicable URAC Standard

Core 8	Staff operational tools and support.
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Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:
A	11-20-09	Initial Release	Susan Glomb	Ken Fasse	n/a
01	12-04-09	Annual Review- No changes	Susan Glomb	Ken Fasse	Dec.2009
02	12-14-10	Annual Review – no changes	Susan Glomb	Ken Fasse	Dec.2010
03	02-18-11	Policy updated to reflect current practice	Susan Glomb	Ken Fasse	
04	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri	
05	11-07-11	Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011
06	1-3-12	Updated policy to reflect current practices for Medicare/Commercial members.	Susan Glomb	Dr. B. Almasri	Jan. 2012
07	04-03-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri	
08	12-10-12	Annual Review – Policy changed to reflect those plans subject to PPACA	Susan Glomb	Dr. B. Almasri	Dec 12
09	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri	
10	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	
11	10-29-15	Annual Review. Changed frequency to one per birth as stated in ACA.	Lisa Wojno	Dr. B. Almasri	October 2015
12	11-16-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2016
13	11-17-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	November 2017

14	11-16-18	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	November 2018
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