

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 too 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

Rental or purchase of a manual or standard electric breast pump is considered reasonable and necessary for breastfeeding in the postpartum period – and in conjunction with each birth.

Rental of a heavy duty electrical (hospital grade) breast pump is considered reasonable and necessary for the period of time that a newborn is detained in the hospital – and in conjunction with each birth when allowed per State Medicaid.

Breast pump supplies are covered and include:

- 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

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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.
- Infant's age (gestational age, if premature)
- Mother's discharge date (**not applicable to SHP plans – [see box below](#)**)
- Anticipated duration of need.

Associated supplies needed for the operation of the breast pump are included in the rental. Purchased breast pumps allow for replacement of breast pump supplies for the duration of breast feeding.

As determined by the health plan, in some instances, both manual and electric breast pumps are covered for the purposes of the nursing mother returning to work or school, in addition to medical reasons. Requests for breast pumps for these purposes are to be referred to Northwood Case Review for coverage determination.

In most cases 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 unless payable by State Medicaid requirements. Requests for hospital grade breast pumps are to be referred to Northwood Case Review for coverage determination.

Quantity Limits

1. A4287 - quantity allowed follows the specific State guidelines/limits.

For all plans:

The hands-free breast pump (e.g., Willow) now coded as E0603 is considered a deluxe item, therefore, not reasonable and necessary because it contains features not required for the expression of breast milk.

HCPCS Level II Codes and Description

A4281	Tubing for breast pump replacement
A4282	Adapter for breast pump replacement

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A4283	Cap for breast pump bottle replacement
A4284	Breast shield & splash protectr w/breast pump repl
A4285	Polycarbonate bottle use w/breast pump repl
A4286	Locking ring for breast pump replacement
A4287	Disposable collection and storage bag for breast milk, any size, any type, each.
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.

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Northwood follows all CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), as applicable.

References

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SPECIAL COVERAGE INFORMATION PER PLAN:

SHP – All SHP Plans	Mother's discharge date is no longer required. Member does not need to be discharged before receiving equipment.
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Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:	Effective 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	12-10-12	Annual review. Policy changed to reflect those plans subject to the Patient Protection and Affordable Care Act.	Susan Glomb	Dr. B. Almasri	Dec. 2012	
07	12-18-13	Annual review. No changes	Susan Glomb	Dr. B. Almasri		
08	11-25-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
09	10-29-15	Annual Review. Added 'in conjunction with each birth' under those plans governed under ACA.	Lisa Wojno	Dr. B. Almasri		
10	11-16-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	November 2016	

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11	11-14-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	November 2017	
12	11-14-18	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	November 2018	
13	11-01-19	Annual Review. No Changes.	Lisa Wojno	Dr. C. Lerchin	November 2019	November 2019
14	1-14-20	Added Willow handsfree breast pump information to policy indicating it is considered a convenience item, therefore not reasonable and necessary.	Susan Glomb	Dr. C. Lerchin	January 2020	January 2020
15	11-5-20	Annual review. No additional changes – see above entry.	Carol Dimech	Dr. C. Lerchin	November 5, 2020	November 5, 2020
16	10-18-21	Revised hcpcs code description K1005 to reflect current language. Willow Wearable Breast Pump information updated per CMS, added: Existing code category E0603 "Breast pump, electric (ac and/or dc), any type" adequately describes the Willow Breast Pump.	Carol Dimech	Dr. C. Lerchin	10-18-21	10-18-21
17	10-26-21	Revised to indicate Willow-style pump is considered deluxe therefore not reasonable and necessary.	Carol Dimech	Dr. C. Lerchin	10-26-21	10-26-21
18	11-02-21	Annual Review. Only changes are regarding the Willow pump 10-26-21	Carol Dimech/Susan Glomb	Dr. C. Lerchin	11-2-21	
19	11-8-21	Added NCD, LCD verbiage to "Important Note".	Carol Dimech	Dr. C. Lerchin	11-8-21	
20	2-1-22	Updated policy with SHP criteria – see Special Coverage Information Per Plan box.	Carol Dimech	Dr. C. Lerchin	2-1-22	2-1-22

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21	11-4-22	Annual Review. Added HCPCS codes A4281, A4282, A4283, A4284, A4285 and A4286 to Level II HCPCS Codes and Description section. Updated policy to be reflective Medicaid coverage and further aligning with The Affordable Care Act.	Lisa Wojno	Dr. C. Lerchin	11-4-22	
22	8-29-23	Added Quantity Limits heading and information.	Carol Dimech	Dr. C. Lerchin	8-29-23	8-29-23
23	11-7-23	Annual review. Added Aetna reference.	Carol Dimech	Dr. C. Lerchin	11-7-23	11-7-23
24	12-05-23	Removed K1005 and replaced with A4287 effective January 1, 2024	Susan Glomb	Lisa Wojno	12-05-23	January 1, 2024