Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP354

Section: Medical Policy

Subject: Breast Pump

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Breast Pump

II. Purpose/Objective:

To provide a policy of coverage regarding breast pumps

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking

into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

CRITERIA FOR COVERAGE:
Breast pumps are considered to be medically necessary during the 3rd trimester or postpartum period for breastfeeding when any of the following criteria are met:

- Normal pregnancy and/or delivery of a healthy baby; or
- The mother is unable to nurse or unable to provide breast milk adequately for her infant(s); or
- The infant has a medical condition or congenital disorder that interferes with feeding; or
- Expression of milk after delivering a stillborn infant; or
- While the mother takes medications that can be found in breast milk and would pose a risk to her infant(s).

A new set of breast pump supplies (i.e., initial tubing, shields, and bottles) are necessary with each subsequent pregnancy

A replacement manual or standard electrical breast pump is considered medically necessary for each subsequent pregnancy, for initiation or continuation of breastfeeding during pregnancy or following delivery.

LIMITATIONS:
Coverage for breast pump will be limited to the standard manual or personal-use, double-electric breast pump.

A member may request a heavy duty electrical (hospital grade) or deluxe pump, but the member will be responsible for any cost over and above that of the standard breast pump.

EXCLUSIONS:
The following items are considered to be disposable or are otherwise non-covered:

- Pump cleaning supplies including but not limited to antibacterial soap, sprays, wipes, or steam cleaning bags
- Nursing bras, bra pads, breast shells, and other products or garments to allow hands-free pump operation

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Breast Pumps
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

A4281 Tubing for breast pump, replacement
A4282 Adapter for breast pump, replacement
A4283 Cap for breast pump bottle, replacement
A4284 Breast shield and splash protector for use with breast pump, replacement
A4285 Polycarbonate bottle for use with breast pump, replacement
A4286 Locking ring for breast pump, replacement
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
E1399 Durable medical equipment, miscellaneous [when specified as a wireless or wearable breast pump]

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. Optimizing support for breastfeeding as part of obstetric practice. ACOG Committee Opinion number 756.

Meier PP, Johnson TJ, Patel AL, Rossman B. Evidence-based methods that promote human milk feeding of preterm infants: an expert review. Clin Perinatol. 2017;44(1):1-22.

Johns HM, Forster DA, Amir LH, McLachlan HL. Prevalence and outcomes of breast milk expressing in women with healthy term infants: a systematic review. BMC Pregnancy Childbirth. 2013;13:212

Flaherman VJ, Gay B, Scott C, Avins A, Lee KA, Newman TB. Randomised trial comparing hand expression with breast pumping for mothers of term newborns feeding poorly. Arch Dis Child Fetal Neonatal Ed. 2012;97(1):F18-23.

Becker GE, Smith HA, Cooney F. Methods of milk expression for lactating women. Cochrane Database Syst Rev. 2016;9:CD006170.

Meier PP, Patel AL, Hoban R, Engstrom JL. Which breast pump for which mother: An evidence-based approach to individualizing breast pump technology. J Perinatol. 2016;36(7):493-499.

This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 12/21

Revised:

Reviewed: 4/23