PROVIDER POLICIES & PROCEDURES

HOSPITAL-GRADE BREAST PUMPS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for hospital-grade breast pumps. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

The American Academy of Pediatrics (AAP) and The American Academy of Family Physicians (AAFP) recommend that (1) most babies be exclusively breastfed for the first six months of life; (2) breast feeding should continue with the addition of complementary foods throughout the second half of the first year; and (3) breastfeeding beyond the first year should continue as long as mutually desired by mother and infant. Breastfeeding has well documented short and long term medical and neuro-developmental advantages for both infant and mother and few known contraindications.

Expressing breast milk can be accomplished in a number of ways. Breast pumps are medical devices regulated by the Food and Drug Administration (FDA) often used by breastfeeding women to express milk when babies are not able to nurse directly from the breast or are not efficiently removing milk. Breast pumps are also used to maintain or increase a woman's milk supply, relieve engorged breasts and plugged milk ducts, or pull out flat or inverted nipples so a nursing baby can latch-on to its mother's breast more easily.

Manual and electric breast pumps, that are *not* designed for reuse, are the most commonly used pumps utilized by mothers with healthy infants who are working, traveling or for other reasons not always home to breast feed their baby. Standard electric breast pumps or manual breast pumps may also be used to initiate breast feeding during the immediate postpartum period.

Hospital-grade breast pumps are electric pumps designed to be (1) safely and hygienically used by multiple users; (2) durable enough to be used by mothers expressing milk often; and (3) capable of initiating and supporting milk supply.

CLINICAL GUIDELINE

Coverage guidelines for hospital-grade breast pumps are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines *only.* Coverage determinations are based on an assessment of the individual and her unique clinical needs.

Hospital-grade breast pumps may be considered medically necessary when a mother is unable to use a standard breast pump **and** when her infant is unable to nurse directly from the breast. Circumstances in which the infant cannot nurse normally include, but are not limited to:

- Prematurity (including multiple gestation);

- Neurologic disorder;
- Genetic abnormality;
- Anatomic or mechanical malformation (e.g. cleft lip or palate); or
- Congenital malformation requiring surgery (e.g. respiratory, cardiac, gastrointestinal or central nervous system malformation).

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of hospital-grade breast pumps is required. Requests for coverage of hospital-grade breast pumps will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

Hospital-grade breast pumps are available as rentals only. If approved, initial authorization will be given for a period of time not to exceed three months. Subsequent requests for authorization should include clinical documentation supporting the continued need for a hospital-grade breast pump.

The following information is needed to review requests for hospital-grade breast pumps:
1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal;
2. Prescription from the ordering practitioner; and
3. Documentation supporting the medical necessity of the item.

Reimbursement:
The hospital grade breast pump will be covered upon the mother's discharge from the hospital HUSKY Health will not reimburse for a pump while the mother is inpatient.

The following are included in the rental payment for a hospital-grade breast pump:
- Set-up and education on the proper use and care of the pump;
- Maintenance and all repairs/replacements needed during the rental period; and
- Applicable cleaning/return service charges.

EFFECTIVE DATE
This Policy is effective for prior authorization requests for hospital-grade breast pumps for individuals covered under the HUSKY Health Program beginning April 1, 2014.

LIMITATIONS
Coverage is limited to rental of hospital-grade pumps.

CODE:

Code	Description
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

1. American Academy of Family Physicians (AAFP). Breastfeeding [position paper]. 2013. Accessed December 6, 2013.
2. American Academy of Pediatrics (AAP). Breastfeeding and the use of human milk. Pediatrics. 2012 Mar; 129:827-841. Accessed December 6, 2013.
3. CMS, Health Care Procedural Coding System Level II Manual: 2020
4. United States Food and Drug Administration. (2013, January). Breast Pumps. From: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BreastPumps/default.htm Accessed December 6, 2013.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	April 1, 2014	
Reviewed	March 16, 2015	Clinical Quality Subcommittee Review Reference updated. Approved at the March 16, 2015 Clinical Quality Sub-Committee meeting.
Updated	August 2015	Updated definitions for HUSKY A, B, C and D programs at request of DSS.
Updated	March 2016	Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline section pertaini to definition of Medical Necessity. Updates throughout policy to reflect importance of person-centeredness when reviewing requests for these items. Changes approved by the Clinical Quality Subcommittee meeting on March 21, 2016. Changes approved by DSS on May 23, 2016.
Updated	August 2016	Clinical Quality Subcommittee Review Reference Updates. Approved at the September 19, 2016 Clinical Quality Sub-Committee meeting. Changes approved by DSS on October 10, 2016.
Updated	August 2017	Reference Updates. Approved at the July 26, 2017 Medical Policy Review Committe meeting. Updates approved by the Clinical Quality Subcommittee on September 21, 2017. Updates approved by DSS on September 22, 2017.
Updated	July 2018	Reference Update. Change approved at the July 25, 2018 Medical Policy Review Committee Meeting. Approved by the CHNCT Clinical Quality Subcommittee on September 17, 2018. Approved by DSS on September 19, 2018.
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		Clinical Quality Subcommittee on June 19, 2019. Approved by DSS on June 21, 2019.
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