

WellCare Health Plans, Inc.
The WellCare Group of Companies

Clinical Coverage Guideline



WellCare Prescription Insurance, Inc.

*'Ohana Health Plan, a plan offered by
WellCare Health Insurance of Arizona, Inc.*

WellCare Health Insurance of Illinois, Inc.



WellCare Health Insurance of New York, Inc.

Harmony Behavioral Health, Inc.

Harmony Behavioral Health of Florida, Inc.

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WellCare of New York, Inc.

WellCare of Connecticut, Inc.

WellCare of Georgia, Inc.

Harmony Health Plan of Illinois, Inc.

WellCare of Ohio, Inc.

Breast Pumps

Guideline Number: HS-027

Original Effective Date: 6/19/2008

Revision Date: 7/17/2009

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

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DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines.

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

CLINICAL COVERAGE GUIDELINE

WellCare considers rental of a reusable breast pump medically necessary durable medical equipment (DME) in the following two instances only:

1. For the period of time that a newborn is detained in the hospital after the mother is discharged; **OR**,
2. For babies who have congenital anomalies that interfere with feeding, breast pump rental is considered medically necessary for the first month after discharge from the hospital.

Note: Breast pump rental is not considered medically necessary once the newborn is discharged from the hospital.

Nonreusable manual or electric breast pumps that are available commercially are not considered by WellCare to fall within the standard definition of durable medical equipment in that they are normally of use in the absence of illness or injury.

New York Medicaid

Rental of hospital grade breast pumps for use in the home requires prior approval. Coverage is limited to the following indications (New York Medicaid Manual):

- Prematurity (including multiple gestation)
- Neurologic disorders
- Genetic abnormalities (e.g. Down's Syndrome)
- Anatomic and mechanical malformations (e.g. cleft lip and palate)
- Congenital malformations requiring surgery (e.g. respiratory, cardiac, gastrointestinal, central nervous system)

- Prolonged infant hospitalization
- Other conditions that prevent normal breastfeeding (e.g. respiratory compromise)

Initial rental approval will be for sixty days. For extreme prematurity (infants less than 28 weeks gestation), the initial rental period may be up to 90 days. Extensions of the approved period of rental will be considered on an individual determination of continuing medical need.

Ohio Medicaid

WellCare considers breast pumps **medically necessary** durable medical equipment (DME) based on the criteria listed below (Ohio Administrative Code 5101:3-10-25: Lactation pumps).

- 1) Lactation pumps are covered by the Medicaid program under the following conditions:
 - The requested lactation pump is subject to the coverage and limitations for medical supplies as defined by the appropriate rule of the Administrative Code
 - The requested lactation pump is prescribed by a physician or advanced practice nurse (APN) involved in the member's care.
- 2) If the lactation pump is purchased, prior authorization is not required.
- 3) Hospital grade (HG) rental lactation pumps **DO NOT** require prior authorization for the first ninety days of the rental period. Prior authorization must be obtained if the rental period exceeds the initial ninety day period. Total rental period for a hospital grade pump may not exceed one hundred and eighty days.
- 4) Reimbursement for a manual or electric lactation pump purchase will include:
 - The cost of the equipment
 - A one year manufacturer's warranty
- 5) Prior authorization for an extension of the rental period for a hospital grade lactation pump must comply with all Administrative Code rules and must include the following documentation:
 - A fully completed and most recent PA form
 - A description of any similar equipment currently in the possession of the member and the reason for the new request
 - Documentation to establish medical necessity
 - Written prescription (less than 30 days old from the time the PA is requested) signed by a physician or APN involved in the member's care, verifying the need of the pump.
- 6) ALL of the following criteria must also be met for the breast pump to be eligible for reimbursement:
 - The HG pump must have a suction and rhythmic rate equivalent to the pump commonly found in the hospital setting (adjustable suction pressure between 100-250 mmHg) and a mechanism to prevent suction beyond 250 mmHg
 - The HG pump must have an adjustable pumping speed capable of reaching 52 cycles per minute

- The HG pump must be cleaned and serviced as needed between rentals
- 7) Rental payments must be considered “all inclusive”, which includes the following components:
- Set up and instructions as to pump and attachment kit usage and cleaning
 - Maintenance and repair during rental period
 - HG attachment kit, which must be new and will become the property of the member
 - Applicable cleaning/return service charges
- 8) “All inclusive” HG accessories are the responsibility of the DME vendor during the initial ninety day rental period. Replacement of any lost or damaged supplies and/or accessories are the responsibility of the member.
- 9) Any manual pump that was supplied to a member as part of an HG pump attachment kit cannot be billed to the Ohio Medicaid program as a separate item by a DME vendor.
- 10) Any member that acquires a manual pump as part of a vendor supplied HG pump attachment kit cannot purchase an additional manual pump at Ohio Medicaid program expense.
- 11) All DME providers must keep member records documentation demonstrating the specific time frame that the pump was being utilized.
- 12) Inpatient pumps and/or DME equipment are NOT COVERED under this rule and cannot be billed separately. These services are considered a component of the diagnostic related group (DRG) payment.

Background

Breast Pumps

Breast pumps may be battery, electrically or manually operated. The manual pump is not recommended for use because it cannot be cleaned properly, and milk may become contaminated (AAP, 2005). Most manual pumps are designed for pumping one breast at a time and are suggested for occasional use (American College of Nurse Midwives [ACNM], 2002). For most women, electric pumps stimulate the breast more effectively than manual expression or hand pumps. Electric pumps are used mainly to continue breastfeeding with expressed milk when the mother is not able to maintain a regular breastfeeding schedule. Regardless of the type of pump used, all parts that come into contact with the mother’s skin or milk should be removable for cleaning (AAP, 2005).

An infant has a suction frequency of 40–126 sucks per minute. Pump simulation of these frequency values provides the best milk production results, because prolactin levels increase when the frequency is physiological relevant. When prolactin levels are high, the breast creates more milk and maintains the milk supply. Prolactin levels also increase when both breasts are emptied simultaneously. If a single pump is used, the pump should be switched from one breast to the other every five minutes. This approach is more effective than fully emptying one breast and then emptying the other (Biagioli, 2003). In addition to sucking *frequency* rates, most breast pumps are designed to empty a breast of its milk by simulating the suction *pressure* of an infant’s suckling. An infant feeds with a suction pressure of 50–220 millimeters of mercury (mm Hg). Suction pressure affects the mother’s comfort, efficiency of milk expression and overall production level of milk. Pumps with suction pressures higher than 220 mm Hg may cause nipple discomfort. Maximal pressures of less than 50 mm Hg may be inadequate to empty the breast. Auto-cycling pumps provide an automatic release of the suction pressure, thereby allowing adequate tissue perfusion between suction cycles.

New York Medicaid Manual Text

Hospital or professional grade breast pump coverage is limited to cases of prematurity (including multiple gestation), neurologic disorders, genetic abnormalities (e.g., Down’s Syndrome), anatomic and mechanical malformations (e.g., cleft

lip and palate), congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, CNS), prolonged infant hospitalization, or other conditions that prevent normal breastfeeding (e.g. respiratory compromise). DVS authorization is available for up to 2 months. Prior approvals required for cases requiring more than 2 months rental (e.g. extreme prematurity, less than 28 weeks gestation).

CODING

Applicable CPT® Codes

No specific code

Applicable HCPCS codes

A4281 - A4286 Breast pump supplies [for rented reusable breast pump pumps only]
E0602 Breast pump, manual, any type [rented reusable only]
E0603 Breast pump, electric (AC and/or DC), any type [rented reusable only]
E0604 Breast pump, hospital grade, electric (AC and/or DC), any type (rented reusable only)

Applicable ICD-9 Procedure Codes

No specific code

Applicable ICD-9 Diagnosis codes

749.00 - 749.25 Cleft palate and cleft lip
750.0 Tongue tie
750.10 - 750.19 Tongue tie and other anomalies of tongue
750.21 - 750.29 Other specified anomalies of mouth and pharynx

This list of codes may not be all-inclusive of congenital anomalies that interfere with feeding of the newborn. Documentation is required to establish medical necessity.

New York Medicaid

Applicable CPT® Codes

No specific code

Applicable HCPCS codes for Rental of Breast Pumps for Home Use

A4281 - A4286 Breast pump supplies [for rented reusable breast pump, pumps only]
E0602 Breast pump, manual, any type [rented reusable only]
E0603 Breast pump, electric (AC and/or DC), any type [rented reusable only]
E0604* Breast pump, hospital grade, electric (AC and/or DC), any type (rented reusable only)
**Limited coverage, refer to the New York Medicaid Manual Text coverage statement above.*

Applicable ICD-9 Procedure Codes

No specific code

Applicable ICD-9 Diagnosis codes

749.00 - 749.25 Cleft palate and cleft lip
750.0 Tongue tie
750.10 - 750.19 Tongue tie and other anomalies of tongue
750.21 - 750.29 Other specified anomalies of mouth and pharynx

758.0	Down's Syndrome
765.01 – 765.03	Extreme immaturity with a birthweight of less than 1000 grams
765.14 – 765.18	Other pretrem infants with a birthweight of 1000 to 2499 grams
770.7	Chronic respiratory disease arising in the perinatal period

This list of codes may not be all-inclusive of congenital anomalies that interfere with feeding of the newborn. Documentation is required to establish medical necessity. Please refer to the Policy statement above for further diagnostic coverage.

Ohio Medicaid

Applicable CPT® Codes

No specific code

Applicable HCPCS Codes

A4281 - A4286	Breast pump supplies [for rented reusable breast pump pumps only]
E0602	Breast pump, manual, any type [rented reusable only]
E0603	Breast pump, electric (AC and/or DC), any type [rented reusable only]
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type (rented reusable only)

Applicable ICD-9 Procedure Codes

No specific code

Applicable ICD-9 Diagnosis codes

749.00 - 749.25	Cleft palate and cleft lip
750.0	Tongue tie
750.10 - 750.19	Tongue tie and other anomalies of tongue
750.21 - 750.29	Other specified anomalies of mouth and pharynx

This list of codes may not be all-inclusive. Documentation is required to establish medical necessity.

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