BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Hospital Grade Electric Breast Pump
Corporate Medical Policy

File Name: Hospital Grade Electric Breast Pump
File Code: 1.03.VT205
Origination: 04/2005
Last Review: 12/2021
Next Review: 12/2022
Effective Date: 02/01/2022

Description/Summary

Breast pumps are used to remove breast milk when babies are not able to nurse directly from the breast or are not efficiently transferring milk. A hospital-grade rental pump is the most effective pump, especially when used with a double pump kit, which allows for pumping of both breasts at once. For a mother whose baby is not able to breastfeed, transfer milk efficiently or is losing weight or gaining weight very slowly, this type of pump is recommended to establish milk supply or re-establish adequate milk supply.

Breast feeding has many health benefits to mother and baby and will reduce overall health care costs. It is widely accepted by pediatricians and parents that breast milk is the gold standard for infant nutrition. Breastfed babies have fewer ear and respiratory infections, allergies, gastro-intestinal diseases, SIDS, lymphoma and Type 1 Diabetes. Mothers who breast feed have quicker return to pre-pregnancy uterine size with less bleeding, decreased risk of breast and ovarian cancer and osteoporosis.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- HCPCS Code Table

When a service may be considered medically necessary

Hospital grade electric breast pumps are available as rentals only and are considered **medically necessary** when one of the following conditions is met:

- When the infant is premature at 24-34 weeks of gestation, and the mother

is pumping breast milk, awaiting the baby's ability to nurse directly from the breast; **OR**

- When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse and transfer milk efficiently from the breast**; OR**

- For infants with cleft lip and/or palate or tongue tie who are not able to nurse directly or efficiently from the breast and achieve good milk transfer; **OR**

- For infants with cardiac anomalies or any medical condition that makes them unable to sustain breast feeding due to poor coordination of suck and swallow, fatigue, neurologic disorder, or genetic abnormality; **OR**

- For multiples (including twins), until breast-feeding at the breast is established consistently with good milk transfer; **OR**

- When the mother has an anatomical breast problem, which may resolve with the use of a hospital grade breast pump, such as inverted nipples; **OR**

- For any infants, for medical reasons, who are temporarily unable to nurse directly from the breast, such as relating to a NICU stay or other separation of the mother and baby, or infants not able to breastfeed, transfer milk efficiently or are losing weight or gaining weight very slowly, or during any hospitalization of the mother or baby which will interrupt nursing; **OR**

- When the infant has poor weight gain in the first four weeks of life related to milk production, and pumping breast milk is an intervention in the provider's plan of care **AND** infant has a documented weight loss of 7% or greater in the first week of life or has not regained birthweight by two weeks of age; **OR**

- When the infant has poor weight gain after four weeks of age related to mother's milk production and pumping breastmilk frequently throughout the day is part of the provider's plan of care along with baby's nursing at breast in an attempt to improve mother's supply; **OR**

- For women who wish to breastfeed their adopted infant or infant born through surrogacy in attempt to induce lactation.

When a service is considered not medically necessary

A hospital grade breast pump is **not medically necessary** when the above criteria are not met or when the request is solely to allow for the mother's return to work, if the mother has elected to pump and bottle feed expressed breast milk (EBM) only, for the mother's or family convenience, or as a substitute for a standard use breast pump when baby or babies

are nursing directly from the breast with good milk transfer and mother is pumping 1-5 times a day to help maintain milk supply or for supplementation.

Rationale/Scientific Background

UpToDate review for Breast milk expression for the preterm infant.
Literature review current through: Nov 2021. | **This topic last updated:** June 25, 2020

Reference Resources

1. Table # 2. Infant Risk Factors for Lactation Problems ABM Clinical Protocol #2 (2014 Revision): Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol"
2. ABM Clinical Protocol # 5: Peripartum breastfeeding management for the healthy mother and infant at term. 2013 Revision
3. ABM Clinical Protocol #10: Breastfeeding the Late Preterm (34–36 6/7 Weeks of Gestation) and Early Term Infants (37–38 6/7 Weeks of Gestation), Second Revision 2016
4. ABM Clinical Protocol #16: Breastfeeding the Hypotonic Infant 2016 revision
5. ABM Clinical Protocol # 17: Guidelines for Breastfeeding Infants with Cleft Lip, Cleft Palate, or Cleft Lip and Palate 2013 Revision
6. ABM Clinical Protocol #7: Model Breastfeeding Policy (Revision 2010)
7. Hwang SS, Barfield WD, Smith RA, et al. Discharge timing, outpatient follow-up, and home care of late-preterm and early-term infants. Pediatrics 2013; 132:101– 108.
8. Ballard JL, Auer CE, Khoury JC: Ankyloglossia: assessment, incidence, and effect of frenuloplasty on the breastfeeding dyad. Pediatrics 110:e63, 2002.
9. U.S. Department of Health and Human Services. The Business Case for Breastfeeding. www.womenshealth .gov/breastfeeding/government-in- action/business-case-forbreastfeeding
10. ABM Clinical Protocol #14: Breastfeeding-Friendly Physician's Office: Optimizing Care for Infants and Children, Revised 2013
11. Protocol # 11: Guidelines for the evaluation and management of neonatal ankyloglossia and its complications in the breastfeeding dyad

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict

between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

04/2005	New Policy
04/2006	Verbiage changes only
06/2007	New medical necessity criteria added and minor verbiage changes made.
07/2007	Reviewed by CAC
06/2008	Annual review. Format has been changed and minor verbiage changes made. No clinical criteria changes. Additional references were added on page 3.

07/2008	Reviewed by CAC
09/2011	Updated and transferred to new format. Minor language changes.
10/2011	Medical/Clinical Coder reviewed and approved coding
07/2012	Format updated. Updated to reflect Women's Health Mandate, effective 8/1/12 upon renewal. Better Beginnings® language removed
07/2012	MD, RN and Medical/Clinical Coder reviewed and medical policy committee (MPC) approved.
09/2015	Medically and not medically necessary criteria updated. HCPCS codes beginning with "A" in this policy no longer require prior approval unless they are over dollar threshold. MPC approved.
09/2017	Minor rewording formatting, new medical criteria around adoptive mom and baby over 4 weeks. Added language around surrogate mothers. Updated rationale and references.
10/2018	Reviewed policy updated references no changes to policy statement.
12/2020	Reviewed policy. No changes to policy statement.
12/2021	Policy reviewed. Minor formatting changes. Clarified lactation induction criteria. No change to policy statement.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

*If the pump and collection kit is not available via a participating DME provider, then the member may rent the pump through their local hospital or lactation consultant.

Approved by BCBSVT Medical Directors Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Attachment I
HCPCS Code Table

Code Type	Number	Description	Policy Instructions
The following codes are considered as medically necessary when applicable criteria have been met.			
HCPCS	A4281	Tubing for breast pump, replacement	Prior approval required if the purchase price is over the dollar threshold – Refer to Corporate Prior Approval list
HCPCS	A4282	Adapter for breast pump, replacement	
HCPCS	A4283	Cap for breast pump bottle, replacement	
HCPCS	A4284	Breast shield and splash protector for use with breast pump, replacement	
HCPCS	A4285	Polycarbonate bottle for use with breast pump, replacement	
HCPCS	A4286	Locking ring for breast pump, replacement	
HCPCS	E0604	Breast Pump, Hospital Grade, electric (AC and/or DC), any type.	Prior Approval Required