Clinical Policy: Electric Breast Pumps

Reference Number: GA.CP.MP.500
Date of Last Revision: 02/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Peach State Health Plan (PSHP) follows the Georgia Medicaid Division Department of Community Health Durable Medical Equipment Services, Electric Breast Pumps authorization guidelines. This clinical policy provides medical necessity guidelines for coverage of Electric Breast Pumps.

Policy/Criteria

I. It is the policy of Peach State Health Plan that electric breast pumps are medically necessary for infants under one year of age with at least one of the following indications:

A. Breast pump, hospital grade, electric, any type, HCPCS code E0604-RR (Rental):

1. Request is for breast pump rental for the duration of the Neonatal Intensive Care Unit (NICU) or hospital stay and the breast pump will be returned to the vendor upon discharge, and one of the following:
   a. Prolonged infant hospitalization (NICU) after the mother is discharged due to preterm birth, low birth weight or other congenital anomaly;
   b. Infant is readmitted to the hospital during the first three months of life.

Note: *If the medical condition requiring the use of a breast pump is expected to continue due to a neurological or congenital anomaly or oral deformity after the baby is discharged home, then the physician should order the home use electric breast pump (HCPCS code E0603) prior to or at the time of discharge.*

B. Breast pump, electric (AC and/or DC), any type, HCPCS code E0603-NU (Purchase):

1. Initial purchase, one of the following:
   a. Infant has a congenital anomaly that interferes with the ability to breastfeed (Example: Cleft lip or palate, Down Syndrome, Pierre-Robin Syndrome, Oral deformity);
   b. Infant has neurological issues (Example: Cerebral or Facial Palsy);
   c. Infant has a long-term condition causing sickness or weakness, preventing the ability to breastfeed;
   d. Infant was discharged home from a prolonged NICU hospitalization and requires the use of a hospital grade rental pump.
2. Replacement, both of the following:
   a. The initial pump was approved over three years previously, or is broken and out of warranty;

b. Request is for a subsequent pregnancy, for breastfeeding during pregnancy, or following delivery.

II. Reimbursement Guidelines:

A. The infant's Medicaid ID number must be documented on the request to purchase a breast pump after discharge when medically necessary.

Background

This Utilization Review Guideline provides assistance in interpreting Peach State Health Plan benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plans, coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Utilization Review Guideline is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Utilization Review Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Utilization Review Guideline. Other Policies and Guidelines may apply. Peach State Health Plan reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

Peach State Health Plan may also use tools developed by third parties, such as the Change Healthcare InterQual™ guidelines, and other consensus guidelines and evidence-based medicine, to assist us in administering health benefits. The Change Healthcare InterQual™ Care guidelines and other are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-todate sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
E0603	Breast pump, electric (AC and/or DC), any type
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type (rented reusable only)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Codes	Description
G51.0	Bell's palsy or facial palsy
G80.0-G80.9	Cerebral palsy

G81.00-G81.04	Flaccid hemiplegia
G81.10-G81.14	Spastic hemiplegia
G81.90-G81.94	Hemiplegia, unspecified
P05.00 - P05.09	Newborn light for gestational age
P05.10 - P05.19	Newborn small for gestational age
P07.00 - P07.03	Extremely low birth weight newborn
P07.10 - P07.18	Other low birth weight newborn
P07.20 - P07.26	Extreme immaturity of newborn
P07.30 - P07.39	Preterm [premature] newborn [other]
P94.0-P94.9	Disorders of muscle tone of newborn
P27.0-P27.9	Chronic respiratory disease originating in the perinatal period
Q20.0-Q20.9	Congenital malformations of the circulatory system
Q21.0-Q21.9	Congenital malformations of the cardiac septa
Q22.0-Q22.9	Congenital malformations of pulmonary and tricuspid valves
Q23.0-Q23.9	Congenital malformations of aortic and mitral valves
Q24.0-Q24.9	Other congenital malformations of heart
Q25.0-Q25.9	Congenital malformations of great arteries
Q26.0-Q26.9	Congenital malformations of great veins
Q35.1 - Q35.9	Cleft palate
Q36.0 - Q36.9	Cleft lip
Q37.0 - Q37.9	Cleft palate with cleft lip
Q38.0 - Q38.8	Other congenital malformations of tongue, mouth and pharynx
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
Q87.11	Prader-Willi Syndrome
Q90.0-Q90.9	Down Syndrome

***Note**: **This list of diagnoses codes may not be all-inclusive of neurological or congenital anomaly or oral deformity that interferes with feeding of the infant. Documentation is required to establish medical necessity**.*

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed 01/2020. Approved by the Georgia Medicaid Department of Community Health (DCH) on 03/31/2020.	01/2020	03/2020

Description: minor changed last sentence wording from "clinical guidelines" to "medical necessity guidelines". **II. Reimbursement Guidelines**: added word "number" after Medicaid ID and "when medically necessary" to end of sentence. **ICD-10 table update**. Updated range of ICD-10 codes: P05.00-P05.09 for Newborn light for gestational age diagnoses. Updated References.	03/2021	03/2021
Annual review. Updated References.	02/2022	02/2022
Annual review. Updated References.	02/2023	02/2023
Annual review. Updated References.	01/2024	02/2024
Annual review. Updated References.	02/2025	02/2025

References

1. Part II Policies and Procedures for Durable Medical Equipment Services. Georgia Department of Community Health, Division of Medical Assistance Plans. Policy 1109.3 Electric Breast Pumps. 01/2020. 04/2020. 01/2021.01/2022. 10/2022. 01/2024. 01/2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.