MEDICAL POLICY STATEMENT
MARKETPLACE PLANS

Original Issue Date	Next Annual Review	Effective Date
09/01/2017	09/01/2018	09/01/2017
Policy Name		**Policy Number**
Breast Pumps and Lactation Services		MM-0110
Policy Type		
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination

Contents of Policy

D. POLICY

I. Comprehensive lactation services by a trained consultant and the use of standard electric or manual breast pumps along with supplies are considered medically necessary and are a Patient Prot
effective August 1, 2012.

A. The following are covered services:
   1. Standard electric or manual breast pumps
   2. Breast pump supplies, including the following:
      2.1 Breast pump tubing
      2.2 Breast pump adapter
      2.3 Breast pump bottle cap
      2.4 Breast pump locking ring
      2.5 Breast pump polycarbonate bottle
      2.6 Breast shield and splash protector

B. Hospital-grade and heavy-duty breast pumps are considered covered services for the following indications:
   1. The breastfeeding infant is confined to the hospital; **OR**
   2. The breastfeeding infant has a medical or congenital condition that impedes breastfeeding such as:
      2.1 Cardiac, respiratory or genetic conditions
      2.2 Cleft palate or other congenital condition

C. Exclusions:
   1. Breast feeding supplies that are considered supplies for the purposes of convenience such as: storage or freezer bags and containers, bottles and nipples

Note: CareSource members are able to access trained consultant information on the CareSource website: https://www.caresource.com/healthy-living/healthy-family/healthy-pregnancy/breastfeeding/

E. CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATES	ACTION
Date issued	09/01/2017	
Date Revised		
Date		