



April 2006
Revised:
October 2007

ATTENTION PROVIDERS

CMS-1500
Bulletin
06-003

An Important Notice for Wyoming Medicaid Providers

Effective May 1, 2006, the policy for breast pump purchase and rental will be as follows:

Criteria for Purchase

E0603—Breast pump, electric, any type

EqualityCare covers purchase of standard grade electric breast pumps (E0603) through a cooperative agreement with the Wyoming Women, Infants and Children (WIC) program under the following conditions:

1. Prescribing provider (Physician, Nurse Practitioner or Physician Assistant) certifies that breastfeeding is medically necessary for the infant; AND
2. Mother has received education regarding health, nutritional, immunologic, developmental, psychological, social and economic benefits of breastfeeding from the prescribing physician; or
3. Mother has initiated contact with and plans to receive follow-up support from a community breastfeeding program such as WIC, La Leche League or the community Public Health Nursing Office; or
4. Infant is pre-term or low birth weight with increased nutritional needs; or
5. Infant requires hospitalization longer than the mother; or
6. Infant has diagnosis of cleft palate, cleft lip, Down's Syndrome, cardiac problems, Cystic Fibrosis, PKU, neurological impairment, failure to thrive or other conditions that necessitate breastfeeding; or



7. Infant has cranial facial abnormalities or is unable to suck adequately;
or
8. Infant has severe feeding problems.

Criteria for Rental**

E0604—Breast pump, heavy duty, hospital grade

EqualityCare covers rental of breast pump, heavy duty, hospital grade (E0604) when documentation of medical necessity is supplied by the prescribing provider. **PRIOR AUTHORIZATION IS REQUIRED**. Pumps may be rented for up to a three month time period under the following conditions:

1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short-term rental of breast pump; or
2. Mother is hospitalized due to illness or surgery on a short-term basis;
or
3. Mother will receive short-term treatment with medications that may be transmitted to the infant; or
4. Pediatric Healthcare provider determines need for short term rental of heavy duty pump due to a serious medical condition of the infant.

**** Special Considerations:**

Breast pump rental claims should be submitted to ACS with the *mother's Medicaid identification number* using the RR modifier for rental. Please indicate the TH modifier for the breast pump starter kit. Please submit written order as well as EqualityCare Certificate of Medical Necessity—Electric Breast Pumps form for Prior Authorization.

If you have additional questions regarding billing or covered services, please contact the ACS Provider Relations Unit at (307) 772-8401 or toll free at (800) 251-1268. Call center hours are Monday through Friday from 9am-5pm.

EqualityCare
Wyoming Department of Health
Certificate of Medical Necessity
Electric Breast Pump E0603, E0604

Section A CLIENT AND PROVIDER INFORMATION

| | |
|---------------------|----------------------------|
| Client Name _____ | Prescribing Provider _____ |
| Medicaid ID # _____ | Provider ID # _____ |
| Date of Birth _____ | Telephone # _____ |

Section B CLINICAL INFORMATION (MUST BE COMPLETED BY THE PRESCRIBING PROVIDER)

DIAGNOSIS : INFANT

DIAGNOSIS : MOTHER

Section C—Applies to purchase of Single User Pump (E0603) through cooperative agreement with Women, Infant and Children (WIC) Program—SUBMIT CLAIM WITH INFANT’S MEDICAID ID #

Circle all that apply:

- Y N 1. Breastfeeding is medically necessary for this infant AND
- Y N 2. Mother has initiated contact with and will receive follow-up support from a community breastfeeding program such as WIC, La Leche or a community Public Health Nursing Office; or
- Y N 3. You have provided Mother with education regarding health, nutritional, immunologic, developmental, psychological, social, economic and environmental benefits of breastfeeding; or
- Y N 4. Infant is pre-term or low birth weight with increased nutritional needs; or
- Y N 5. Infant requires hospitalization longer than the mother; or
- Y N 6. Infant has diagnosis of cleft palate, cleft lip, Down’s Syndrome, cardiac problems, cystic fibrosis, PKU, neurological impairment, failure to thrive or other conditions that result in the inability to breastfeed; or
- Y N 7. Infant has cranial facial abnormalities or is unable to suck adequately; or
- Y N 8. Infant has severe feeding problem. Please describe:

Section D—For rental of breast pump, heavy duty, hospital grade (E0604) - up to 3 months only. SUBMIT CLAIM WITH MOTHER’S MEDICAID ID NUMBER AND PRIOR AUTHORIZATION #:

Circle all that apply:

- Y N 1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short-term rental of breast pump; or
- Y N 2. Mother is hospitalized due to illness or surgery on a short-term basis; or
- Y N 3. Mother is to receive short-term treatment with medications that may be transmitted to the infant; or
- Y N 4. Healthcare provider certifies that short-term use of this type of breast pump is medically necessary due to medical condition on infant. Please describe:



Section E—PRESCRIBING HEALTHCARE PROVIDER ORDER:

Section F—PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE AND DATE:

Signature of Prescribing Provider _____ **Date** _____

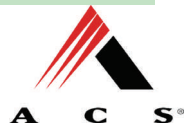


Wyoming Department of Health
Public Health Insurance Program



Pharmacy
Group
6530

Important Changes! Please read!



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We're on the Web!

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