Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Donor Breast Milk for Maine Products

Effective: September 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

The use of donor human breast milk can be beneficial for high-risk infants, primarily infants born weighing less than 1500 grams or those who have a severe intestinal disorder. Pasteurized donor milk provides the nutritional and immunologic benefits of breast milk and reduces infectious complications in preterm or low birthweight infants compared for formula milk.

In accordance with Maine S.P. 126 – L.D. 267 “An Act to Require Private Insurance Coverage for Donor Breast Milk” a carrier shall provide coverage for pasteurized donor breast milk provided to an infant eligible for coverage under the health plan. For the purposes of this guideline, an infant is defined as persons less than one year of age.

Coverage of donor breast milk may vary by plan, please see the member’s plan documents for additional detail.

Clinical Guideline

Pasteurized banked donor breast milk may be considered reasonable and medically necessary when prescribed by providers with prescribing authority **ALL** of the following are met:

1. The infant is medically or physically unable to receive maternal breast milk or participate in breastfeeding; **or**
2. the infant’s parent is medically or physically unable to produce maternal breast milk in quantities sufficient for the infant; **and**
3. The infant meets **ONE** of the following
    a. Birth weight is less than 1500 grams; **or**
    b. Member has a gastrointestinal anomaly, metabolic or digestive disorder, or is recovering from intestinal

surgery and the member's digestive needs require additional support; **or**

c. The member is experiencing failure to thrive; **or**
d. The member has formula intolerance and is experiencing weight loss or difficulty feeding; **or**
e. The member has low blood sugar; **or**
f. The member has congenital heart disease; **or**
g. The member has received or will receive an organ transplant; **or**
h. The member has a medical condition for which donor breast milk is required

Limitations

The Plan considers donor breast milk as not medically necessary for all other conditions. In addition, The Plan considers donor breast milk as not medically necessary for:

1. Banked donor milk for healthy, normal birthweight infants
2. Banked donor milk provided for convenience
3. Banked donor milk when not prescribed by a treating provider

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
T2101	Human breast milk processing, storage, and distribution only

References:

1. Maine P.L. 2021, Ch. 708 (L.D. 85), *An Act Concerning MaineCare Coverage for Donor Breast Milk:* https://www.maine.gov/dhhs/oms/providers/provider-bulletins/donor-breast-milk-coverage-infants-under-12-months-cr-113541-2022-12-22, Accessed August 4, 2026
2. Tran HT, Nguyen TT, Mathisen R. The use of human donor milk. *BMJ*. 2020;371:m4243. Published 2020 Nov 17. doi:10.1136/bmj.m4243

Approval And Revision History

October 18, 2023: Reviewed by the Medical Policy Approval Committee (MPAC) as a coverage guideline, effective January 1, 2024
Subsequent endorsement date(s) and changes made:

- August 30, 2024: Reviewed by MPAC, renewed without changes, effective October 1, 2024
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- July 15, 2026: Reviewed by MPAC for annual review, renewed without changes effective September 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to

eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.