

**December 2020**

Benefit Updates

**Human Donor Milk Coverage Effective January 1st, 2020**

CountyCare will now cover human donor milk effective January 1, 2020. Pasteurized human donor milk (breast milk which has been donated to a Human Milk Banking Association of North America [HMBANA] member milk bank) is covered for members who meet the coverage and policy requirements outlined below. The Mothers' Milk Bank of the Western Great Lakes is the only HMBANA-accredited milk bank in Illinois and Wisconsin that processes and distributes donated human milk.

**To be considered for coverage, donated human breast milk must:**

* …be obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health, and is enrolled as a provider in the Illinois Medical Assistance Program;
* …provided in situations where the infant’s mother is medically or physically unable to produce maternal breast milk or produce sufficient quantities to meet the infant’s needs, or the maternal breast milk is contraindicated;
* …be determined medically necessary for the infant and the infant meets the specific requirements for based on his/her age.

For an infant **under the age of six (6) months**, one or more of the following must apply:

* The infant’s birthweight is below 1,500 grams; OR
* The infant has a congenital or acquired condition that places the infant at a high risk for developing necrotizing enterocolitis; OR
* The infant has active treatment of hypoglycemia; OR
* The infant has congenital heart disease; OR
* The infant has had or will have an organ transplant; OR
* The infant has sepsis; OR
* The infant has any other serious congenital or acquired condition for which the use of donated breast milk is medically necessary and supports the treatment and recovery of the infant.

For a **child six (6) months through twelve (12) months of age**, one or more of the following must apply:

* The child has a diagnosis of spinal muscular atrophy; OR
* The child’s birthweight was below 1,500 grams and he or she has long-term feed or gastrointestinal complications related to prematurity; OR
* The child has had or will have an organ transplant; OR
* The child has any other serious congenital or acquired condition for which the use of donated breast milk is medically necessary and supports the treatment and recovery of the child

For a **child twelve (12) months of age or older**, the following must apply:

* The child has spinal muscular atrophy



**Limitations**

 The following is applied to determine the appropriate amount of milk for the request:

* Primary: 25-35 ounces per day
* Supplemental: may vary

Form HFS 1305-N must be submitted with all requests

* The form must be completed in its entirety
* A new order is required every 6 months
* Reasons noted on the form for why the birth mother is unable to provide milk must be support by evidence-based reasons. This may include:
	+ Medical condition of mother
	+ Premature birth
	+ Formula intolerance
	+ Food allergies
	+ Malabsorption syndromes
	+ Immunologic deficiencies
	+ Pre or post-operative nutrition and immunologic support

**To request approval for human donor milk, providers must submit supporting clinical documentation and a completed HFS form 1305 (N-7-20) to CountyCare UM via the** [**provider portal**](http://www.countycare.com/providers/portal) **or via fax to 1-866-209-3703.**

**Contact Us**

If you have any questions or would like additional information, please contact CountyCare Provider Services at ProviderServices@countycare.com or your Provider Relations Representative.