

Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring Prior Authorization



Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 888 647-6152

Reduction Mammoplasty (Bilateral)

Member

Date: _____ (Need to verify eligibility/benefits)
 Last Name: _____ First Name: _____
 ID #: _____ DOB: _____
 Plan/Product Type: EPO SF-POS PPO Medicaid
 Primary Care Physician: _____ Surgeon: _____
 PCP Phone: _____ PCP Fax: _____

Clinical Information: Height: _____ Weight: _____ *BSA: _____
Estimated Breast Tissue Removal in Grams: R Breast: _____ L Breast: _____

Type of Request: (check #1 or #2)

- (1) Patient meets all the criteria below – this is a fax notification of surgery and is not medically reviewed
- Patient 18 years or older or breast growth is complete
 - PCP has referred the patient
 - The patient has symptoms adversely affecting activities of daily living and quality of life that are directly attributable to macromastia and that have not responded to conservative measures. The symptom score must be greater than or equal to 3.
 - The operating surgeon documents the estimated amount of breast tissue to be removed must be more than the minimum amount for a given body surface area (BSA) according to the Schnur Sliding Scale.

$$*BSA = \frac{Ht.(Inches) \times Wt. (Lbs.)}{3131}$$

- (2) Patient does not meet criteria in #1. **Medical review is required. Include copies of all supporting documentation and the primary care office medical records from the last 6 months. Patient must meet all criteria under Criteria Set A or Criteria Set B.**

Criteria Set A (All)

- Patient 18 years or older or breast growth is complete
- Symptom score must be greater than or equal to 3 (*see below)
- Evaluation by a Physiatrist who has determined that BOTH:
 - Pain is not related to musculoskeletal condition (e.g. arthritis, spondylitis, acromioclavicular strain) and
 - Reduction mammoplasty is likely to result in improvement of the chronic pain

Criteria Set B (All)

- Patient 18 years or older or breast growth is complete
- Symptom score must be greater than or equal to 3 (*see below)
- Persistent pain and related symptoms despite a 6 month trial of therapeutic measures
 - Physical therapy, chiropractic care, osteopathic manipulation therapy
 - Supportive devices (e.g. fitted bra)
 - Analgesics/NSAIDs

***Symptoms:** (check appropriate box for severity)

Severe	Moderate/Mild	N/A	
<input type="checkbox"/> 3.0	<input type="checkbox"/> 1.5	<input type="checkbox"/>	Digital (finger) paresthesia
<input type="checkbox"/> 2.0	<input type="checkbox"/> 1.0	<input type="checkbox"/>	Occipital headaches
<input type="checkbox"/> 2.0	<input type="checkbox"/> 1.0	<input type="checkbox"/>	Cervical lordosis, thoracic kyphosis, or neck pain
<input type="checkbox"/> 2.0	<input type="checkbox"/> 1.0	<input type="checkbox"/>	Lumbar lordosis or low back pain
<input type="checkbox"/> 1.0	<input type="checkbox"/> 0.5	<input type="checkbox"/>	Breast pain
<input type="checkbox"/> 1.0	<input type="checkbox"/> 0.5	<input type="checkbox"/>	Grooves on shoulder from brassiere or shoulder pain
<input type="checkbox"/> 1.0	<input type="checkbox"/> 0.5	<input type="checkbox"/>	Intertrigo: rash under breasts
<input type="checkbox"/> 1.0	<input type="checkbox"/> 0.5	<input type="checkbox"/>	Asymmetry of the breasts (>30% difference)

Schnur Sliding Scale Body surface area and cutoff weight of average breast tissue removed			
Body Surface Area (m ²)	Average grams of tissue per breast to be removed	Body Surface Area (m ²)	Average grams of tissue per breast to be removed
1.35	199	2.00	628
1.40	218	2.05	687
1.45	238	2.10	750
1.50	260	2.15	819
1.55	284	2.20	895
1.60	310	2.25	978
1.65	338	2.30	1068
1.70	370	2.35	1167
1.75	404	2.40	1275
1.80	441	2.45	1393
1.85	482	2.50	1522
1.90	527	2.55	1662
1.95	575		

The following web site gives several different formulas and a link to a calculator for them: <http://www.halls.md/body-surface-area/refs.htm>.

Limitations and Exclusions are as follows:

- a. Mastopexy procedures (e.g. breast ptosis) are not a covered benefit. These procedures are considered to be cosmetic in nature and not performed to relieve pain due to macromastia.
- b. Reduction mammoplasty for cosmetic purposes (to improve appearance) is not a covered benefit.
- c. Reduction mammoplasty to treat fibrocystic disease of the breasts is not a covered benefit.
- d. Regardless of the Schnur Sliding Scale, breast reduction removing less than 350 grams from a breast is considered a cosmetic procedure and is not a covered benefit.
- e. Chronic intertrigo, eczema, dermatitis, and/or ulceration in the inframammary fold, in and of itself, are not an indication for coverage.
- f. Coverage is limited to one reduction mammoplasty per member lifetime with Priority Health.

ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW

For Priority Health Use Only:

- Approved
- Denied, does not meet Schnur Scale or Symptom Score or Both
- Denied, has not failed physical therapy and/or specially fitted brassier