Prior Authorization Form

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

Fax Form To: 616 942-0024

Reduction Mammoplasty (Bilateral)

Member

Date: ______________________________ *(Need to verify eligibility/benefits)*

Last Name: ______________________________ First Name: ______________________________

ID #:______________________________ DOB: ______________________________

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.

☐ (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 physician 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
  - ☐ Supportive devices (e.g. fitted bra)
  - ☐ Analgesics/NSAIDs

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

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

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

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*****