BlueCross BlueShield Minnesota

Reduction Mammoplasty (Medical Policy IV-32)
Commercial Pre-Authorization (PA) Request Form

Please refer to medical policy criteria on providers.bluecrossmn.com for clinical review criteria prior to submission

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross**. Please complete the clinical sections on this form and attach it to your request at **Availity.com** to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request, to (651) 662-2810.

Patient Information

Will waiting the standard review time seriously jeopardize the life or health of the member or the member's ability to regain maximum function? ☐ Yes ☐ No

Member ID: _____ Group number: _____

Member name: _____ Date of birth: ___ /___ /_____

Member address: _____

Member city/state/zip: _____

Member phone: ____-____-_____

Servicing Provider Information

Contact person: _____ Phone: ____-____-_____

Servicing provider name: _____

Servicing provider ID/NPI number: _____

Servicing provider address: _____

City/state/zip: _____

Servicing provider phone: ____-____-_____ Servicing provider fax: ____-____-_____

Inpatient/Outpatient Facility name: _____ Facility ID: _____

Ordering Provider Information

Ordering provider name: _____

Ordering provider ID/NPI number: _____

Ordering provider address: _____

City/state/zip: _____

Ordering provider phone: ____-____-_____ Ordering provider fax: ____-____-_____

Services/Procedures/ Items Requested

HCPC/CPT Code(s)	HCPC/CPT Code(s) Description	ICD-10 Diagnosis Code(s)	Start Date mm/dd/yy	End Date mm/dd/yy

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Patient History

Please attach all relevant clinical documentation that supports information selected in the form.

Diagnosis (check ONE of the following):

☐ Macromastia

☐ Other (please provide diagnosis): _____

Please check ONE of the following:

☐ Bilateral procedure planned

☐ Unilateral procedure planned

Patient Criteria:

Height: _____ (feet) _____ (inches) Weight: _____ (lbs.)
Body Surface Area (BSA): _____ (m^2)

BSA should be calculated by Mosteller Formula referenced on the Schnur Sliding Scale:
BSA (m^2) = SQR RT ([Height(in) x Weight(lbs.)] / 3131)

Online BSA calculators are available at:

- https://www.easycalculation.com/medical/bsa-Mostellers.php
- https://qxmd.com/calculate/calculator_28/bmi-and-bsa-mosteller

Notes:

- Links to online BSA calculators are provided as a convenience, the actual BSA calculation formula will prevail over output from an online BSA calculator if there is a difference.

- If a bilateral procedure is planned the weight to be removed from at least one breast must meet criteria above. If a unilateral procedure is planned, the breast on which surgery will be performed must meet criteria above.

Please check all of the following that apply:

Note: There should be, at least, TWO of the following for, at least, the past 6 months and clinical documentation attached must support indications selected as well as duration:

☐ Shoulder, neck, or back pain that is not responsive to at least 6 weeks of conservative therapy (e.g., appropriate support bra, exercises, heat/cold treatment, and appropriate non-steroidal anti-inflammatory agents [NSAIDS]/muscle relaxants)
☐ Recurrent or chronic intertrigo between the pendulous breast and the chest wall
☐ Persistent shoulder grooving
☐ Neurologic symptoms associated with brachial plexus pressure (e.g., numbness or tingling of the shoulder, arm, or hand)
☐ Other (Please describe below):

Patient History	**If patient is age 40 or older:** Has patient undergone preoperative imaging that was negative for cancer within the year prior to surgery? ☐ Yes ☐ No If, yes, please attach a written report describing negative findings.
Surgical Criteria	Is the amount of breast tissue to be removed greater than 600 grams per breast? ☐ Yes ☐ No If, no, please indicate the amount of breast tissue (not fatty tissue) to be removed from each breast. Left Breast: _____ (grams) Right Breast: _____ (grams) **Note:** If a range of breast tissue to be removed is submitted, the lower number of the range will be used as the planned tissue reduction in determining medical necessity.

Please attach all relevant clinical documentation that supports information selected in the form.

Description/Additional Information:

Total pages: _____

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