



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

REDUCTION MAMMAPLASTY PRIOR AUTHORIZATION REQUEST

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ **RECIPIENT MEDICAID ID:** _____

RECIPIENT HEIGHT: _____ **RECIPIENT WEIGHT:** _____

DOES RECIPIENT HAVE ALTERNATE INSURANCE PLAN? YES NO

NAME OF INSURANCE PLAN: _____

PROVIDER INFORMATION

DATE OF REQUEST: ___/___/_____ **CONTACT PERSON #:** _____

PROVIDER NAME: _____ **NH MEDICAID PROVIDER #:** _____

ADDRESS: _____ **CITY/STATE/ZIP:** _____

TELEPHONE #: _____ **FAX #:** _____

MEDICAL NECESSITY CRITERIA FOR BREAST REDUCTION SURGERY

Breast Reduction surgery for non-cosmetic indications for women age 18 or older or for whom growth is complete will be covered when **either** criteria A or B are met **or** criteria C and D are both met.

PLEASE CHECK ALL OF THE CRITERIA BELOW THAT APPLY

A. Macromastia: All of the following criteria must apply:

- Patient has persistent symptoms affecting daily activities for at least one year. Pain in upper back, neck, shoulders, resulting in a physical disability or loss of function or restriction of physical activity, **OR**
- Pain or severe discomfort or ulceration from bra straps cutting into shoulders.

AND

- Provider documents that chronic pain symptoms are caused by macromastia.

AND

- Pain or severe discomfort or ulceration from bra straps cutting into shoulders.

AND

Patient has undergone an evaluation by a provider who has determined that all of the following have been met:

- The pain cannot be solely explained by a musculoskeletal condition (e.g. arthritis, spondylitis,) **and**
- Reduction mammoplasty is likely to result in improvement of the chronic pain; **and**
- Pain symptoms persist as documents by provider despite two trials of 3-month duration, of adequate conservative treatment with support garments NSAIDs, physical therapy, exercise program or posturing maneuvers.

OR

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.



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B. Chronic dermatitis:

Dermatitis lasting greater than 6 months that has not responded to conservative measures such as antibiotics, hygiene.

AND

C. Amount of breast tissue to be removed:

Surgeon estimates that at a minimum 250 to 500 grams of breast tissue will be removed from each breast. Additional clinical guidance about the amount of tissue to be removed can be based on the Schnur Sliding Scale with the amount of tissue to be removed from each breast expected to be at least above the 22nd percentile. This minimum amount may be reviewed retrospectively through chart review and retrospectively withdrawn if not met.

AND

D. Cosmetic surgery:

Surgery is **NOT** being performed due to Breast Asymmetry*

**Medicaid does not cover breast reduction surgery for the purpose of correcting symmetry in a member who does not otherwise meet the above stated criteria; such treatment is considered cosmetic.*

Proposed amount of tissue to be removed from each breast: _____

BSA: _____

CLINICAL INFORMATION:

Please attach physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

I certify that the above information is true and accurate to the best of my knowledge.

Signature

Date

Please print:

Name/Title

Specialty

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