Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
T: 877.825.9293 | F: 414.918.8038

Reduction Mammoplasty

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Member's height _____ Member's weight _____

The member is 18 years or older ..... ☐ Yes ☐ No

Estimated amount of tissue to be removed per breast _____

The member's Schnur Scale results _____

The member has significant physical functional impairment..... ☐ Yes ☐ No

This procedure is expected to reasonably improve the physical and functional impairment..... ☐ Yes ☐ No

The member has signs and/or symptoms resulting from the breast hypertrophy that have not responded adequately to any non-surgical interventions..... ☐ Yes ☐ No

The member has any of these anatomical body areas affecting activities of daily living:

- Pain in upper back..... ☐ Yes ☐ No
- Pain in neck..... ☐ Yes ☐ No
- Pain in shoulders..... ☐ Yes ☐ No
- Headache..... ☐ Yes ☐ No
- Painful kyphosis documented by x-rays..... ☐ Yes ☐ No

The member has severe submammary intertrigo or shoulder grooving with ulceration that is refractory to conventional medications and conservative measures for a period of 6 months or more... ☐ Yes ☐ No

There is documentation from a primary care physician and other providers, as appropriate (e.g. physiatrist, orthopedic surgeon), showing the diagnosis and evaluation of symptoms that prompted this request, which confirms all of the following:

- There is a reasonable likelihood that the member's symptoms are primarily due to macromastia..... ☐ Yes ☐ No
- Reduction mammoplasty is likely to result in improvement of the chronic pain ..... ☐ Yes ☐ No

- Pain symptoms persist, as documented by the physician, despite at least a 3-month trial of therapeutic measure, such as:
  - Analgesic or non-steroidal anti-inflammatory drugs (NSAIDs) interventions. . . . . ☐ Yes ☐ No
  - Physical therapy, exercise, or posturing maneuvers . . . . . ☐ Yes ☐ No
  - Supportive devices (e.g. proper bra support, wide bra straps). . . . . ☐ Yes ☐ No
- Women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty. . . . . ☐ Yes ☐ No
- Date of mammogram (month/day/year) _____ /_____ / _____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:

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If you have any questions, please contact Customer Service at 1.877.514.2442