

Review Request for Breast Procedures including Reconstructive Surgery, Implants and Other Procedures

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 8/28/08	Policy Effective Date: 10/01/08	Provider Tool Effective Date: 8/10/09
----------------------------------	---------------------------------	---------------------------------------

Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

Please check all that apply to the member:

Reconstructive Breast Surgery

After Mastectomy or the Treatment of Breast Cancer

- Procedure is to rebuild the normal contour of the affected breast to produce a more normal appearance
- Procedure is to rebuild the normal contour of the contralateral unaffected breast to produce symmetry or a more normal appearance and involves (check all that apply):
 - Reduction mammoplasty
 - Augmentation mammoplasty with implants
 - Mastopexy
 - Other (please describe): _____
- Member has had a mastectomy, lumpectomy or other breast surgery to treat breast cancer
- Procedure includes the following to construct a more normal appearance: (check all that apply)
 - Reconstructive surgery
 - Implant insertion
 - Member's muscle tissue being transposed from another site
 - Other (please describe): _____

After Prophylactic Mastectomy

- Procedure is planned/was done on both breasts following bilateral prophylactic mastectomy
- Other (please describe): _____

For the Indication of Breast Disfigurement

- Procedure is to alter the contour of the breast of a member with significant abnormalities related to: (check all that apply)
 - Trauma
 - Congenital defects
 - Infection
 - Poland's syndrome as diagnosed by: (check all that apply)
 - Congenital absence or hypoplasia of pectoralis major and minor muscles
 - Breast hypoplasia
 - Congenital partial absence of the upper costal cartilage
 - Other (please describe): _____
 - Other non-malignant disease (please list): _____

Management of Breast Implants

Removal of Breast Implants

- Breast implant, originally inserted for reconstructive purposes, is associated with a significantly altered appearance, such that the goals of reconstruction (i.e., to return the patient to a whole) are not reached
- Request is for removal of breast implants unrelated to a history of mastectomy, lumpectomy or diagnosis of breast cancer
- Removal is due to systemic symptoms attributed to connective tissue disease, autoimmune diseases, etc.
- Removal is as a result of patient anxiety
- Removal is due to pain not related to contractures or rupture

Silicone Gel-filled Implants

- There is documentation of implant rupture (i.e., using mammography, ultrasound, or MRI)
- Removal is due to infection
- Removal is due to implant exposure/extrusion
- Removal is due to pain related to capsular contracture (clinically confirmed as Baker Class IV)
- Removal is prior to surgical treatment of breast cancer (Note: Implant explantation is routinely performed at the time of mastectomy. In patients treated with breast conserving surgery [i.e., lumpectomy], a breast implant may or may not interfere with subsequent treatment, and thus explantation at the time of lumpectomy is at the discretion of the treating physician and the patient.)
- Other (please describe): _____

Saline-filled or Alternative Implants

- Removal is due to infection
- Removal is due to implant exposure/extrusion
- Removal is due to pain related to capsular contracture (clinically confirmed as Baker Class IV)
- Removal is prior to surgical treatment of breast cancer. (Note: Implant explantation is routinely performed at the time of mastectomy. In patients treated with breast conserving surgery [i.e., lumpectomy], a breast implant may or may not interfere with subsequent treatment, and thus explantation at the time of lumpectomy is at the discretion of the treating physician and the patient.)
- Other (please describe): _____

Combination Implants (i.e., consisting of both silicone and saline-filled material)

- There is documentation of rupture of the silicone component using mammography, ultrasound or MRI
- Removal is due to infection
- Removal is due to implant exposure/extrusion
- Removal is due to pain related to capsular contracture (clinically confirmed as Baker Class IV)
- Removal is prior to surgical treatment of breast cancer. (Note: Implant explantation is routinely performed at the time of mastectomy. In patients treated with breast conserving surgery [i.e., lumpectomy], a breast implant may or may not interfere with subsequent treatment, and thus explantation at the time of lumpectomy is at the discretion of the treating physician and the patient.)
- Other (please describe): _____

Other Procedures

- Request is for removal and reimplantation of breast implants related to a history of mastectomy, lumpectomy or treatment of breast cancer
- Removal and reimplantation is due to ruptures or development of a visible distortion (Baker Class III contracture)
- Request is for surgery on the unaffected breast to produce a symmetrical appearance as a result of removal and reimplantation of breast implants for treatment of physical complications of the implant or reconstruction
- Request is for reimplantation of implant originally inserted for cosmetic purposes after removal due to implant rupture, infection, implant exposure/extrusion, or pain related to capsular contracture (Baker Class III contracture)
- Request is for breast lift, implant repositioning, repair of inverted nipples, or mastopexy other than reasons listed above
- Other (please list): _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**