NOTICE OF ACTION
FOR DENIED SERVICES OR GOODS

DATE: **June 22, 2010**

TO:

FROM: Prior Authorization Department
Aetna Better Health
151 Farmington Ave., RS46
Hartford, CT 06156
1-866-742-3120

Your Provider's Request for Authorization for Bilateral Reduction Mammoplasty is denied for the following reason:

The service your provider requested is not medically necessary: Aetna Better Health was asked to pay for goods or services for you. We looked at your specific medical condition. We looked at the information provided. We looked at the **Aetna Policy on Breast Reduction. The request was for a specific amount of tissue removal. With the facts given, the amount of tissue to be removed does not meet what is considered medically necessary based on your height and weight. Therefore, with the facts as given, we will not pay for this surgery as it is not medically necessary or appropriate.

** Aetna's Clinical Policy Bulletin

The decision to deny your provider's request is based on "**CT General Assembly, PUBLIC ACT 10-3, Section 22**. For a copy of this definition, follow this link to Section 22(NEW): *http://www.cga.ct.gov/2010/ACT/PA/2010PA-00003-R00HB-05545-PA.htm or you may contact Aetna Better Health's Member Services Department to ask for a copy. A copy of **guidelines is also available by contacting Member Services.

There are also special Medicaid rules ("EPSDT") regarding medical services for children and youth under the age of 21. Aetna Better Health must provide members under 21 with all medically necessary Medicaid-covered prevention, screening, diagnostic and treatment services listed in Section 1905 (r) of the Social Security Act, or 42 U.S.C. § 1396d(r). These services must be provided even if they are not on the list of services that Aetna Better Health usually provides for adults.

SEE THE ENCLOSED NOTICE FOR AN EXPLANATION OF HOW TO FILE AN APPEAL.

Sincerely,

Gary Rhule, MD
Medical Director
Aetna Better Health

AmeriChoice
by UnitedHealthcare

NOTICE OF ACTION
FOR DENIED SERVICES OR GOODS

May 20, 2010

To:

ID#:

From: AmeriChoice by United Healthcare
PO Box 31364
Salt Lake City, UT 84131-0361

Your Doctor's Request for a total abdominal hysterectomy is denied for the following reason:

The medical information does show that you meet the Milliman guidelines*:

- You have not received hormone therapy
- You have not had an endometrial biopsy

The decision to deny your provider's request is based on PUBLIC ACT 10-3, Section 22, HOUSE BILL 5545. For a copy of this definition, follow this link: http://www.cga.ct.gov/2010/AMD/H/2010HB-05545-R00HA-AMD.htm, or call AmeriChoice at 1-866-315-2323 for a copy.

*A copy of these guidelines is also available by contacting AmeriChoice at 1-866-315-2323.

SEE THE OTHER SIDE OF THIS NOTICE FOR AN EXPLANATION OF HOW TO FILE AN APPEAL.

Case 9

Community Health Network
of Connecticut, Inc. ™

NOTICE OF ACTION
FOR DENIED SERVICES OR GOODS

September 01, 2010

TO: [redacted]

MEMBER NAME: [redacted]
MEMBER ID NUMBER: [redacted]
GROUP ID: Husky
DIAGNOSIS: 784.2 - Swelling Mass Or Lump In Head And Neck

FROM: Community Health Network of Connecticut, Inc.
11 Fairfield Boulevard
Wallingford, CT 06492

Your provider's request for authorization for Excision of Lesion, forehead , is denied for the following reason :

Community Health Network was asked to pay for Excision of Lesion, forehead. There are guidelines we used to make sure the procedure is needed and not cosmetic. One of the criteria is that there has to be a medical condition.. Based on the information from your doctor, you do not have a medical condition. Therefore we cannot pay for the procedure.

The decision to deny your provider's request is based on RCSA 17b-262-531 - if based on medical necessity, cite "CT General Assembly, PUBLIC ACT 10-3, Section 22." For a copy of this definition, follow this link to Section 22 (NBW): http://www.cga.ct.gov/2010/ACT/PA/2010PA-00003-R00HB-0554-PA.htm, or you may contact CHNCT Member Services Department at 1-800-859-9889 for a copy. *A copy of this [criteria] [guidelines] is also available by contacting Member Services.

There are also special Medicaid rules ("EPSDT") regarding medical services for children and youth under the age of 21. Community Health Network of Connecticut, Inc. must provide members under 21 with all medically necessary Medicaid-covered prevention, screening, diagnostic and treatment services as listed in Section 1905(r) of the Social Security Act, or 42 U.S.C. § 1396d(r). These services must be provided even if they are not on the list of services that Community Health Network of CT provides for adults.

PLEASE SEE THE ENCLOSED INFORMATION ON HOW TO FILE AN APPEAL.