[redacted]

BlueCross BlueShield Minnesota

P.O. Box 64560
St. Paul, MN 55164-0560

September 7, 2018

Corrected Letter

SOPHIA UHLENKAMP
[redacted]

RE: Member Name: SOPHIA UHLENKAMP
Date of Birth: [redacted]
Member ID: [redacted]
Group ID: [redacted]
Provider Name: [redacted]
Reference Number: [redacted]

Dear SOPHIA UHLENKAMP:

A psychiatrist has completed a review of the information provided to us requesting coverage for the services below.

Service	Start Date	End Date	Total Denied
Inpatient - Psychiatric RTF	09-05-2018	09-07-2018	3 Days

These services or supplies are not approved because they do not meet the criteria for medical necessity based on:

Does not Medical Necessity Criteria Per McKesson Interqual, 2017 Child and Adolescent Psychiatry, Subset Inpatient. Specifically she does not have Eating Disorder symptom or treatment complications due to medical issues. She has been able to adequately restore weight. Her weight is within normal limits. Your needs can be met with outpatient treatment.

As stated in your plan document, your coverage provides benefits for only those covered services, drugs, and supplies that are medically necessary and appropriate for the diagnosis or treatment of a specific illness, injury, or condition.

Medical necessity is defined as a need for particular services or supplies that a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate.

For additional information, please see the following section of your plan document:

Child & Adolescent Behavioral Health

You may request any or all of the following documentation free of charge by calling the number on the back of your member ID card or by faxing a request to (651) 662-2810.

- A copy of any policy, criteria, guideline, document, record or other information referenced in making this determination.
- The credentials or relevant information of the reviewing provider in connection with the determination.
- A copy of the diagnosis and/or procedure code including description.

This determination has been made for coverage purposes. In all situations the provider must use his/her professional judgment to provide care he/she believes to be in the best interest of the patient. As always, the provider and member are responsible for treatment decisions.

Although your health plan will not cover this service, you can choose to receive the treatment at your own expense or have other sources pay for it. If you receive services after we have denied coverage, your provider can bill you for the cost of such services. You may also be responsible for payment of services from out-of-network providers. Please contact your provider to learn how much you might be charged for this service.

If your provider would like to discuss this case with a psychiatrist reviewer prior to initiating the formal appeal process, please call **1-855-315-4039**. This would not be considered an appeal and will not reverse the denial. This is a tool used to understand why the denial was issued. If you wish to request an appeal of this decision, please follow the steps outlined in the appeal rights descriptions attached to this letter.

Our Case Managers are available to help you coordinate your care. We can also work with your physician or other health care providers. If you would like to speak with a Case Manager, please call us at **1-866-489-6947 (TTY 711)**. Our office hours are Monday through Friday from 8 a.m. to 5 p.m.

If you have questions about this letter, please call Member Services at the number on the back of your identification card.

Sincerely,

Medical Management

Attachments: MN Appeal Rights

cc: ALLISON STOLZ

BlueCross BlueShield Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

December 14, 2017

SOPHIA UHLENKAMP
[redacted]

RE: Member Name: SOPHIA UHLENKAMP
Date of Birth: [redacted]
Member ID: [redacted]
Group ID: [redacted]
Provider Name: [redacted]
Reference Number: [redacted]

Dear SOPHIA UHLENKAMP:

A psychiatrist has completed a review of the information provided to us requesting coverage for the services below.

Service	Start Date	End Date	Total Denied
Inpatient - Psychiatric RTF	12-14-2017	12-27-2017	14 Days

These services or supplies are not approved because they do not meet the criteria for medical necessity based on:

McKesson
Adolescent Psychiatry Eating Disorder
The clinical information submitted by your provider does not show that you need 24 hour supervision. You do not appear to need supervision for safety or for health risks. Your symptoms should be able to be managed with Intensive Outpatient treatment

As stated in your plan document, your coverage provides benefits for only those covered services, drugs, and supplies that are medically necessary and appropriate for the diagnosis or treatment of a specific illness, injury, or condition.

Medical necessity is defined as a need for particular services or supplies that a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

No benefits will be provided unless it is determined that the service or supply is medically necessary and appropriate.

For additional information, please see the following section of your plan document:

Child & Adolescent Behavioral Health

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Sincerely,

Medical Management

Attachments: MN Appeal Rights

cc: ALLISON STOLZ