Regence | 1800 Ninth Avenue, P.O. Box 21267
Seattle, WA 98111-3267

February 24, 2010

ELIZABETH R LANDY
16637 SE 10TH ST
BELLEVUE WA 98008-6017

Re: Elizabeth R. Landy
Ref# 1005300383701

Dear Ms. Landy:

This letter is regarding a claim submitted for computer aided detection (CAD) with MRI rendered to Elizabeth R. Landy on January 27, 2010. We are writing to explain the coverage as it relates to these services.

The Regence BlueShield Medical Policy Workgroup, which is comprised of licensed medical physicians, has created Medical Policies used when evaluating medical procedures. Our Regence Medical Policy Computer Aided Evaluation of Malignancy with Magnetic Resonance Imaging of the Breast, Radiology 51, considers the above service(s) to be investigational. Your member contract includes a definition for investigational services or supplies. The contract also outlines that your health plan excludes coverage for investigational services, supplies, and related complications. As a result, the above service(s), any associated services or supplies, including related complications will not be covered by your health plan and are full member liability. You can obtain a copy of the applicable Medical Policy and the investigational definition from your health plan, free of charge, by calling the telephone number on the back of your member card.

Coverage of the requested service is denied because Regence Medical Policy considers this service to be investigational. There is insufficient scientific evidence from well-designed clinical studies to determine whether or not the addition of computer-aided evaluation (CAE) to MRI of the breast provides an improved clinical benefit to patients with known or suspected breast cancer. The Regence Medical Policy detailing the rationale for this determination is published at www.regence.com/trgmedpol/radiology/rad51.html

If you disagree with our decision, you have the right to request a review either verbally or in writing. This is the first level of the appeal process. Enclosed is an overview of this process. A complete description of the member appeal process is available upon request, free of charge.

We regret this determination is not favorable to your request. Our policy is not a judgement of the severity of the patient's condition or your medical judgement. We are unable to provide benefits beyond the limitations established under the insured's medical plan.

If you have any questions, please contact Customer Service at 1-800-458-3523.

Sincerely,

Beverly Fernandes
Regence BlueShield
Medical Management Analyst

Enclosure

cc: Mark S. Justus, M.D.

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Appeal Process Overview

Regular Process

First Level – You must request a review within 180 days of this notice. When we receive your first level request for review, we will send you an acknowledgement letter, including a complete description of the entire member appeal process applicable to your plan. First level review will be done by a Grievance Coordinator and a decision will be made within 30 days.

Subsequent Levels – If you disagree with the decision made in the first level review, you have the right to additional review under the member appeal process for your plan. Our letter to you regarding your appeal will include steps you can take to request further appeals, or you can obtain this information any time by contacting our Customer Service Department.

Expedited Process

When is Expedited Appeal Review Available? The expedited process if available only when a request is made for benefits *prior* to receiving care or treatment (pre-service claims.) Expedited review is available when you or your physician reasonably believes determination under the regular process timeframes could jeopardize your life, health or ability to regain maximum function. Expedited review is also available when a physician familiar with you and your medical condition believes that determination under the regular process timeframes would subject you to severe pain that cannot be adequately controlled without the care that is being considered.

First Level – If you disagree with a decision that we have made on a pre-service claim, you have 180 days from the date we notify you of our decision to request a review. When we receive your first level request for expedited review, we will send you an acknowledgement letter that includes a complete description of the entire member appeal process applicable to your plan. First level expedited review will be completed by a panel made up of a nurse appeal coordinator, medical director and administrative representative. We will reach a decision as quickly as possible, usually in one day. In every case, a determination will be made within 72 hours.

Subsequent Levels – If you disagree with the decision made in the first level expedited review, you have the right to additional review level(s) under the member appeal process for your benefit plan. We will outline steps you can take to request further appeals in our correspondence written first level expedited decision. You also can always obtain this information any time by contacting our Customer Service Department.

Subsequent Action

Upon exhaustion of the full member appeal process for your plan, you may have a right to pursue voluntary appeal procedures and, for most members, covered by a private employer sponsored group coverage (not public employer group or individual coverage), may bring action under Section 502(a) of ERISA