Exhibit B 12/16/13

Indiana University Health

Medical Management

Date of Notice: 10/1/2013
Name of Plan: IU Health Employee Plan
Telephone: 317-816-5170
Address: IU Health Plans, PO Box 627 Columbus, IN 47202

This document contains important information that you should retain for your records.

This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in part or in whole, for the requested treatment or services described below. If you think this determination was made in error, you may have the right to appeal (see page 2 for information about your external review rights).

Case Details:

Name: [redacted]	
Reference: [redacted]	**Date of Service:** [redacted]
Provider: [redacted]	

Reason for Denial: The guidelines do not support long term benefits for lymphedema.

Amt. Charged	Allowed Amt.	Other Insurance	Deductible		Coinsurance	Other Amts. Not Covered	Amt. Paid
N/A	N/A						

Diagnosis: Right Lower Extreity Lymphedema

Background information:

DME request for a pneumatic compression device was received on 09/05/2013
The Medical Management team reviewed the request and sent to the Plan's medical director on 09/05/2013
The Plan's medical director reviewed the clinical documentation and denied services on 09/06/2013
The appeals coordinator received an appeal request by email on 09/19/2013

The appeal coordinator prepared documentation and sent out via web to AMR on 09/23/2013:
Denial letter
Clinical documentation received from Tactile Systems
Milliman Guidelines
Letter from member

09/24/2013: Response received electronically
Findings:

This patient is a 63 year old male who is being evaluated for right foot edema. This is a review of the request for pneumatic compression device.

1. Based on the provided guideline/policy, is the requested service medically necessary? Please explain in detail. **No**

   This patient has right lower extremity lymphedema with the request for pneumatic compression pump. According to the submitted Milliman Care Guidelines, long term benefits are not proven for lymphedema. Using Milliman guidelines, further studies are needed to determine the long-term benefit and impact. More research is especially true for the requested Flexitouch system for this patient.

The Plan denies the request for a pneumatic compression device.

UnitedHealthcare
Community Plan
P.O. Box 31364, Salt Lake City UT 84131-0364

November 25, 2013

[redacted]

Member ID#:
Document ID#: [redacted]

Subject: First Level Appeal Decision

Dear [redacted]

UnitedHealthcare has reviewed your first level appeal about the denial of Flexi Touch drainage system, received on November 1, 2013.

Based on a review of all information provided, UnitedHealthcare has decided that the decision is upheld. The reasons for this decision are: A Medical Director of the Health Plan that was not previously involved in this request has reviewed the documentation received for this request. The previous determination for this request has been upheld. Your doctor has asked for insurance coverage for a special device called a FlexiTouch drainage system. He has asked for this to reduce your left arm swelling. Your health plan uses rules to determine if this special device is medically necessary for you. The rules follow guidelines from sources such as the MCG [a medical treatment scientific review] and your health plan. Your health plan requires that you use medical treatments that are effective for your condition. The treatments must also be cost-effective for your condition. This is when compared to alternative interventions, including no intervention. The use of special systems [like the one prescribed by your doctor] is not supported by medical scientific studies. This is because these studies do not show that long term outcomes are more favorably impacted by this type of system when compared to standard treatments. The system has not proven to result in consistently superior outcomes compared to standard treatment. Because of the above, the system prescribed by your doctor does not meet your plan definition of a covered service. Your policy only pays for treatments that meet the definition of a covered service. This is a plan benefit interpretation only, based on available clinical information and current plan language, and is not intended to influence decisions regarding ongoing medical care. This review was performed utilizing United Healthcare Policy and the member's health plan criteria. Date of Determination: 11/25/2013. Stephen Lincoln, M.D. Medical Director, Appeals and Grievances, Board Certified in: Thoracic and Cardiovascular Surgery, reviewed your appeal.

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If you disagree with this decision, you have several options. You can:

- Appeal for a final level of appeal to UnitedHealthcare. This final level appeal will be reviewed by the CEO or his representative. You have 30 days from the date on this letter to contact UnitedHealth Care. To contact UnitedHealthcare, call 1-800-318-8821 or write to:

  UnitedHealthcare Community Plan
  Grievances & Appeals Department
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

- Call the Statewide Enrollee Help Line (EHL) at 1-800-284-4510 and ask them to review the MCO's decision. If they cannot resolve your case within 10 days of your call, you will receive information from the State of Maryland about how to file an appeal and obtain a fair hearing on your case; or

You may request, free of charge, a paper copy of any relevant documents, records, guidelines or other information that was used in making this decision by contacting **UnitedHealthcare at 800-318-8821**. Some information will require a written request or consent from the member before it can be released.

If you currently are receiving ongoing services that are being denied or reduced, you may be able to continue receiving these services during the appeal process by calling UnitedHealthcare at 1-800-318-8821 or the Enrollee Help Line (EHL) at 1-800-284-4510 within 10 days from receipt of this letter. If your appeal is denied, you may be required to pay for the cost of the services received during the appeal process.

If you have any questions or need assistance, please contact UnitedHealthcare at 1-800-318-8821 and a representative will be happy to assist you. Our representatives are available 24 hours per day, 7 days per week.

Sincerely,

Stephen Lincoln, M.D.
Medical Director

SL/CB

cc: [redacted]

8000003036700000000372831962

UnitedHealthcare Community Plan
9702 Bissonnet, Suite 2200W
Houston, TX 77036

August 7, 2013

[redacted]

Re: [redacted]

Dear [redacted]

You/your doctor/your provider asked for **pneumatic compression device and a segmental pneumatic appliance for use with pneumatic compressor on July 30, 2013.** We cannot approve this request because the service you ask for does not meet one or more of the criteria for medical necessity, as set forth in the managed care contract's definition of "Medically Necessary". Medically Necessary for non-behavioral health related Health Care Services means:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
(c) Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
(d) Consistent with the diagnoses of the conditions;
(e) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
(f) Are not experimental or investigative; and
(g) Are not primarily for the convenience of the Member or Provider

The medical basis for the decision is: **You requested a pump for your swollen legs. This pump is not covered for your condition. It may give you some help for a short time. It has not been proven to help over longer period. The pump is not to be used when you have a deep vein clot in your leg. The pump could also cause other problems with your skin and veins.**

UnitedHealthcare Community Plan is complying with **UHC Policy and Procedures # 108: STAR+PLUS Request for Out of Network Physician or Provider and MCG 17th Edition Care Guideline Ambulatory Care for Intermittent Pneumatic Compression with Extremity Pump.**

UnitedHealthcare Community Plan cannot approve the request for **pneumatic compression device and a segmental pneumatic appliance for use with pneumatic compressor.** The start date for this action is **August 7, 2013.**

Attached are your rights to an Appeal and a Fair Hearing. You have the right to file an Appeal and/or a fair hearing if you do not agree that this request should be denied. If you need help understanding this notice or if you want to learn more, you or your representative can call United Healthcare Community Plan at 1-888-887-9003, TTY: 711 for the hearing impaired. Or write to:

United Healthcare Community Plan
9702 Bissonnet, Suite 2200W
Houston Texas 77036

If you have questions about your UnitedHealthcare Community Plan benefits, or would like to file a complaint about this decision, you can contact UnitedHealthcare Community Plan Member Services toll-free at 1-888-887-9003, TTY: 711, for the hearing impaired. A United Healthcare Community Plan Member Service Advocate can help you file a complaint or a Fair Hearing.

Once you have gone through the United Healthcare Community Plan complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free at 1-866-566-8989.

Or, if you would like to make your request in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations – H-320
PO Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

There is not a time limit on filing a complaint with United Healthcare Community Plan. United Healthcare Community Plan will send you a letter telling you what we did about your complaint, within 30 days from when your complaint got to UnitedHealthcare Community Plan.

Should you need any assistance with Medical Case Management, you can call United Healthcare Community Plan toll-free at 1-800-349-0550.

Sincerely,

James Nadler MD

James Nadler, MD
Medical Director

Cc: Tactile Systems Technology [redacted]

Attachments: How to File a State Fair Hearing
How to File an Appeal
Low Cost Legal Services

United HealthCare Services, Inc. on behalf of UnitedHealthcare Insurance Company
5757 Plaza Drive Cypress
CA124-0129
Cypress, CA 90630

UnitedHealthcare

Patient: [redacted]
Service Ref #:

Member: [redacted]
Member ID:
Group:
Group #:

Letter ID: [redacted]

November 5, 2013

[redacted]

Dear [redacted]

We review health care services requested for coverage under the terms of your health benefit plan to determine if they are medically necessary, as defined in your plan document. We received a request to review services for you. Based on the information submitted, we have determined that the requested service(s) is/are not medically necessary.

Here are the details of our decision:

We have determined that the following is not medically necessary:

- Place of service: Home
- Physician/Health care professional: Garth Rosenberg
- Facility: Tactile Systems Technology
- Dollar amount: $7150.00
- Number of unit(s)/visit(s): 1
- Frequency: Monthly
- Date(s) of service: 10-31-2013 to 01-29-2014
- Date(s) determined not to be medically necessary: 10-31-2013 to 01-29-2014
- Diagnosis: 457.1 Other noninfectious lymphedema
- The reason for our determination is: Your doctor has requested a compression machine for your legs. We reviewed the office notes sent by your doctor. These notes show you have a disease that causes your legs to swell up. We reviewed your health plan medical criteria for compression machines. This kind of machine has not been shown to be safe or effective for your condition. This machine is not a covered benefit under your health plan.
- Denial code: Not applicable
- Claim Amount: Not applicable

RECEIVED
NOV 11 2013
BY:

NOV 11 2013

Type of Treatment	
Procedure Code	**Procedure Description**
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg

We reviewed the following information to make our determination: 2013T0563A, effective date April 1, 2013, Pneumatic Compression Devices and MCG: 17th edition, 2013, Intermittent Pneumatic Compression with Extremity Pump ACG: A-0340 (AC)

If you were required but did not get a referral from your primary physician for this service, your coverage may be at a lower level.

Please note that the information in this letter is not a treatment decision. Treatment decisions are made between you and your physician. Coverage for these services is subject to the terms and conditions of your health benefit plan including exclusions, limitations, conditions and patient eligibility. You are responsible for deductibles, coinsurance, copayments and items not covered by the plan.

If you would like your physician or health care professional to discuss this case with our physician or clinical reviewer, he or she may call the UnitedHealthcare Health Care Professional Services Line at 1-877-842-3210 and select "Care Notification".

If you don't agree with our decision, you have the following options:

Member options

1. You, your physician or your health care professional have the right to request the information we reviewed to make this coverage decision free-of-charge. This includes reasonable access to and copies of all documents, records, health benefit plan provisions, internal rules, guidelines and protocols and any other relevant information. Please mail your request for this information and a copy of this letter to: UnitedHealthcare Central Escalation Unit, ATTN: Document Requests, 4316 Rice Lake Road, Duluth, MN 55811.
2. You have the right to be represented by someone else regarding this decision. To have someone else represent you, call us at the toll-free number on your member ID card, and we will send you the form needed to designate another representative.
3. You or your representative may accept our decision as it stands.
4. You or your representative may request a reconsideration and/or an appeal.

The following information is helpful to us when reviewing an appeal or reconsideration:

- A written appeal request asking us to reconsider our decision
- The specific coverage decision you would like us to review
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position
- A copy of this letter

Mail or fax this information to:

UnitedHealthcare Appeals Unit
P.O. Box 30573
Salt Lake City, UT 84130-0573
Standard Appeal Fax: 801-938-2100
Expedited (urgent) appeal fax: 801-994-1083
Please include description of urgency.

The person who reviews your appeal will not be the person, or a subordinate of that person, who made the original decision.

Typically, you have 180 days from your receipt of this letter to submit an appeal request. If you don't comply with these requirements, you may forfeit your right to challenge a denial or rejection. Inquiring about the

appeals process does not change the time frame to submit an appeal. When we receive an appeal request, we review it within 15 calendar days for services not yet received and within 30 calendar days for services already received. We will notify you in writing of our decision.

Reconsideration
A health care provider acting on your behalf may request a reconsideration of the adverse decision. A decision on reconsideration will be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel. The reconsideration will be completed and the decision provided to your treating health care provider and you in writing within ten working days of receipt of the request for reconsideration.

If your health care provider would like to request reconsideration with us, please have him/her contact the clinical reviewer at:

Christopher J. Kirk, MD

1311 W President George Bush Freeway

Richardson, TX 75080

877-842-3210

Standard Appeal
Typically, you have 180 days from your receipt of this letter to submit an appeal request. If you don't comply with these requirements, you may forfeit your right to challenge a denial or rejection. Inquiring about the appeals process does not change the time frame to submit an appeal. When we receive an appeal request, we review it within 60 working days for services not yet received as well as for services already received. We will notify you in writing of our decision.

Expedited Appeal
When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider has the opportunity to appeal immediately, by telephone, on an expedited basis, an adverse decision or adverse reconsideration, including those situations relating to a prescription to alleviate cancer pain. An expedited appeal may be requested only when the regular reconsideration and appeals process will delay the rendering of health care in a manner that would be detrimental to the health of the patient or would subject the cancer patient to pain.

If we confirm that an expedited appeal is needed, we will complete the review within one business day of receiving the appeal request and any additional information.

To request an expedited (urgent) appeal:

Expedited (urgent) appeal fax: 801-994-1083
Telephone: Call Customer Care at the toll-free number listed on your member ID card.
Please include description of urgency.

You may request an expedited external review at the same time as requesting an expedited internal appeal for urgent care.

Availability of Consumer Assistance/Ombudsman Services
There may be other resources available to help you understand the appeals process. If your plan is governed by the Employee Retirement Income Security Act (ERISA), you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. Additionally, a consumer assistance program may be able to assist you at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond VA 23218

Telephone (in Richmond): (804) 371-9032
Telephone (outside Richmond): 877-310-6560
E-mail: ombudsman@scc.virginia.gov
Website: www.scc.virginia.gov/boi

Other member rights
If your plan falls under the standards established by the Employee Retirement Income Security Act (ERISA), and you have exhausted appeals under the plan, you may also have the right to file a civil action under ERISA.

If you have questions about this letter or other questions related to your health insurance, please call the toll-free member phone number listed on your health plan ID card.

Sincerely,

Christopher J. Kirk, MD
Medical Director

Board Certified in Internal Medicine
Licensed in the following State(s): OR, WA

Copy to: [redacted]
Copy to: [redacted]

Enclosure: *United HealthCare Services, Inc. (UHS) Member Appeal Process for Virginia*

UMR, Inc.
5800 Granite Parkway, Suite 700
Plano, TX 75024

UMR
A UnitedHealthcare Company

October 15, 2013

[redacted]

[redacted]

Dear FACILITY DIRECTOR:

We review health care services requested for coverage under the terms of your health benefit plan to determine if they are medically necessary, as defined in your plan document. We received a request to review services for you. Based on the information submitted, we have determined that the requested service(s) is/are not medically necessary.

Here are the details of our determination:

We have determined that the pneumatic compression device is/are not medically necessary:

- Place of service: Home
- Physician/Health care professional: Dr. Bruce Griswold
- Facility: Tactile Systems Technology Inc.
- Dollar amount: E0652 - $7150 E0667 - $825.00
- Number of unit(s): E0652 E0667
- Number of visit(s): Not Applicable (N/A)
- Frequency: Not Applicable (N/A)
- Date(s) of service: 10/01/2013 – 10/31/2013
- Date(s) determined not to be medically necessary: 10/01/2013 – 10/31/2013
- Diagnosis: 757.0 - Hereditary Edema of Legs

[redacted]VED
OCT 22 2013

The reason for our determination is: The patient is a 34 year old female with hereditary edema of legs. The provider is requesting is a pneumatic compression device. The case notes and clinical information were reviewed. Per MCG ACG: A-0340 Intermittent Pneumatic Compression with Extremity Pump, the use of this device for lymphedema is unproven. It is listed in the "Inappropriate Use" section. Therefore the request is not approved. This device is indicated for DVT (deep vein thrombosis) prophylaxis only per the above guideline.

Completed by a:
Board Certified Physician Reviewer

We reviewed the following information to make our determination: MCG ACG: A-0340 Intermittent Pneumatic Compression with Extremity Pump

Please note that the information in this letter is not a treatment decision. Treatment decisions are made between you and your physician. Coverage for these services is subject to the terms and conditions of your health benefit plan including exclusions, limitations, conditions and patient eligibility. You are responsible for deductibles, coinsurance, copayments and items not covered by the plan.

If you would like your physician or health care professional to discuss this case with our physician or clinical reviewer, he or she may call UMR at 1-800-808-4424.
Please call the number located above if you need diagnosis and/or treatment code information for this claim.

If you don't agree with our decision, you have the following options:

Member options

1. You, your physician or your health care professional have the right to request the information we reviewed to make this coverage decision free-of-charge. This includes reasonable access to and copies of all documents, records, health benefit plan provisions, internal rules, guidelines and protocols and any other relevant information. Please mail your request for this information and a copy of this letter to: UMR Care Management 5800 Granite Parkway, Suite 700 Plano TX 75024
2. You have the right to be represented by someone else regarding this decision. To have someone else represent you, call us at the toll-free number on your member ID card and we will send you the form needed to designate another representative.
3. You or your representative may accept our decision as it stands.
4. You or your representative may request an appeal.

The following information is helpful to us when reviewing an appeal:

- A written appeal request asking us to reconsider our decision
- The specific coverage decision you would like us to review
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position
- A copy of this letter

Mail or fax this information to:

UHC Appeals - UMR
P.O. Box 400046
San Antonio, TX 78229
FAX # 888-615-6584

The person who reviews your appeal will not be the person, or subordinate of that person, who made the original decision.

Typically, you have 180 days from your receipt of this letter to submit an appeal request. If you don't comply with these requirements, you may forfeit your right to challenge a denial or rejection. Inquiring about the appeals process does not change the time frame to submit an appeal. When we receive an appeal request, we review it within 30 calendar days. We will notify you in writing of our decision.

Expedited Internal Appeals

An expedited appeal may be available to you if the medical condition is such that the time needed to complete a standard appeal could seriously jeopardize the patient's life, health or ability to regain maximum function. If we confirm that an expedited appeal is needed, we will complete the review within 72 hours of receiving the appeal request and any additional information. To arrange an expedited appeal, please call the toll-free number listed on your member ID card or fax your appeal request to the UMR Appeals Unit at (888) 615-6584.

You may request an expedited external review at the same time as requesting an expedited internal appeal for urgent care.

Standard External Review

Following completion of the internal appeals process, you or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a notice of an adverse determination.

You can request an external review in writing by mailing or faxing the information to:

UHC Appeals - UMR

P.O. Box 400046
San Antonio, TX 78229
FAX # 888-615-6584

You will be provided more information about the external review process at the time we receive your request.

Expedited External Review
An expedited external review may be available to you if the medical condition (1) is such that the time needed to complete an expedited internal appeal or standard external review could seriously jeopardize the patient's life, health or ability to regain maximum function; or (2) concerns an admission, availability of care, continued stay, or health care item or service for which the patient received emergency services, but have not been discharged from a facility. If we confirm that an expedited appeal is needed, you will receive a decision within 72 hours of receiving the appeal request and any additional information.

To arrange an expedited appeal, please call the toll-free number listed on your member ID card or fax your appeal request to the UMR Appeals Unit at (888) 625-6584.

You will be provided more information about the external review process at the time we receive your request.

Other member rights
If your plan is governed by the Employee Retirement Income Security Act (ERISA), you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

If you have questions about this letter please call the toll-free number listed on your member ID card.

Sincerely,

UMR Care Management

Copy to: [redacted]

OCT 22 2013

NORTHBAY™
MEDICAL CENTER

August 29, 2013

[redacted]

[redacted]

Dear Ms. Harrison:

The requesting provider/physician has asked for the above referenced service. The service requested is being denied by NorthBay HealthCare because there is lack of medical necessity. This decision was based on your medical information.

Specifically, there is no clinical documentation that this option is better for lymphedema than compression stockings. This decision was based on Milliman Care Guidelines Ambulatory Care 17TH Edition , ACG: A-0340.

You may obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request, by calling NorthBay HealthCare Case Management Department at 707-646-5012. You may contact your provider for detailed information about your diagnosis or treatment. This could include the detailed codes and their meanings.

The requesting provider/physician has been advised of this denial and given the opportunity to discuss this determination with NorthBay HealthCare physician reviewer.

How to Dispute This Determination*

If you believe that this determination is not correct, you have the right to appeal the decision by filing a grievance with your health plan. Your health plan requests that you submit your grievance within 180 days from the postmark date of this notice. You or someone you designate (your authorized representative) may submit your grievance verbally or in writing. You may call your health plan to learn how to name your authorized representative.

Compassionate Care, Advanced Medicine, Close to Home.

1200 B. Gale Wilson Blvd.
Fairfield, CA 94533-3587
ph (707) 646-5000