

**STATE OF MICHIGAN**  
**DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES**  
**Before the Director of Insurance and Financial Services**

In the matter of:

[REDACTED]

**Petitioner,**

v

File No. 148465-001

**Blue Cross Blue Shield of Michigan,**

**Respondent.**

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Issued and entered  
this 16<sup>th</sup> day of July 2015  
by Joseph A. Garcia  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On June 24, 2015, [REDACTED] (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On July 1, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through an individual plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on July 8, 2015.

This case can be resolved by applying the terms of the Petitioner's coverage; it does not require a medical opinion from an independent review organization. MCL 550.1911(7).

**II. FACTUAL BACKGROUND**

The Petitioner's health care benefits are defined in the *Blue Cross Premier Bronze Benefits Certificate*<sup>1</sup> (the certificate).

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<sup>1</sup> BCBSM form no. 602F; federal approval 09/13 and state approval 02/15.

On March 5, 2015, the Petitioner had an office visit with his physician and certain laboratory tests were ordered. BCBSM covered the office visit and some of the laboratory tests at 100% of its approved amount. But it denied coverage for these tests, saying they were not covered for the reported diagnosis:

<u>Test</u>	<u>CPT Code</u>	<u>Charge</u>
Vitamin D, 25 hydroxy	82306	\$ 80.00
Hepatitis B surface antibody	86706	40.00
Rubella antibody	86762	40.00
Mumps antibody	86735	38.00
Uric acid; blood	84550	14.00
Urinalysis	81003	7.50
	Total	\$ 219.50

As a result, the Petitioner was responsible out of pocket for \$219.50.

The Petitioner appealed BCBSM's handling of the claims through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated May 19, 2015, affirming its decisions. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly process the claims for the Petitioner's March 5, 2015, laboratory services?

### IV. ANALYSIS

#### Petitioner's Argument

Along with his external review request, the Petitioner included a letter that said:

. . . I had an app[oin]tment for a routine history and physical . . . on 3-5-15. During the visit, labs were ordered as part of the examination. As a physician myself, I wanted to make sure that all the labs were covered under my insurance. I did proceed by calling Blue Cross Blue Shield right before I had my labs drawn. During the phone conversation, I was given the impression that my labs would be covered. However, upon receiving a statement from Blue Cross Blue Shield, it indicated that I would be charged a total of \$219.50. . . . I am currently in the process of starting my fulltime job as in July, 2015. I purchased this insurance plan as temporary. Had I been aware that these labs would be charged to me, I

would have postponed them until I started my fulltime job where I may have had a more comprehensive plan. I did genuinely feel from my phone conversation that my labs were covered. I do have the phone conversation on my Sprint account bill as being at 9:46 am for 8 minutes at the number [REDACTED] on March 5, 2015. I was informed from my denial letter from [BCBSM's customer service representative] that she was unable to locate the phone call from March 5. I am attaching a copy of my cell phone bill which shows evidence that the call was placed (it is underlined and circled). I would appreciate any assistance that you could give me on this matter. . . .

### BCBSM's Argument

In its final adverse determination, BCBSM's representative told the Petitioner:

. . . After review, the payment denial is maintained. Thus, the total of \$219.50 remains your responsibility.

I confirmed that the . . . services you received are not payable under your contract when the reported diagnosis is for a routine physical/screening purpose. The claim with these services was submitted with a diagnosis of general medical exam at a health care facility (diagnosis code V700), which is categorized as routine physical.

You are covered under the [certificate]. According to Page 89 of the *Certificate*:

#### **Preventive Care Services**

To see a list of the preventive benefits and immunizations that are mandated by the Patient Protection and Affordable Care Act (PPACA), you may go to the following website: [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html). You may also contact BCBSM customer service.

#### **We pay for:**

We pay 100 percent of our approved amount for the preventive care services listed below, along with the related reading and interpretation of your test results, only when rendered by in-network providers.

Page 90 of your Certificate clarifies:

#### **Routine Laboratory Services**

We pay for the following services once per member, per calendar year, when performed as routine screening:

- Chemical profile
- Cholesterol testing

Finally, Page 91 and 92 of your certificate explains:

**We do not pay for:**

Screening services other than the ones listed above.

In your appeal and during the managerial-level conference, you specified that you spoke to a customer service representative on March 5, 2015 regarding laboratory services. After review, I was not able to locate any record of a call made to customer service on that date. However, on March 3, 2015 you spoke with a customer service representative and were advised that an annual routine physical is covered at 100 percent of our approved amount once per calendar year. The customer service representative also verified that [your doctor] is an in-network provider. As you already know, the claim submitted for your annual routine physical received on March 5, 2015 was approved and a payment totaling 100 percent of our approved amount was issued to your provider.

As a Grievance and Appeals Coordinator for BCBSM, it is my responsibility to ensure that the claim at issue processed according to plan design. As a result, I am not able to make an exception on your behalf. You remain liable for the non covered charges of \$219.50 to Biotech Clinical Laboratory, Inc.

In a position statement submitted for this review on July 8, 2015, BCBSM further said:

The services [were] denied payment based on the reported diagnosis V70.0 (general medical exam at a health care facility). The services are not payable under the member's contract when reported with a routine/preventive diagnosis.

Director's Review

As the certificate explains (pp. 89-92), the Petitioner's plan will cover, at 100% of the approved amount, a "health maintenance examination"<sup>2</sup> (i.e., a routine or preventive physical examination) once per calendar year when performed by a network provider. As part of that examination, the plan will cover at 100% any preventive benefits and immunizations that are mandated by the federal Patient Protection and Affordable Care Act (PPACA) as well as a chemical profile and cholesterol testing when performed as routine screening. But no other tests are covered as part of a routine or preventive care visit.

The Petitioner had a routine or preventive care visit with his physician on March 5, 2015. The tests that BCBSM declined to cover are not mandated by the PPACA nor are they included

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<sup>2</sup> Defined in the certificate (p. 163) as, "A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors."

in the certificate's list of other preventive care benefits. Therefore, they are not a benefit when performed as part of a routine physical examination.<sup>3</sup>

The Director concludes that BCBSM correctly processed the claims for the Petitioner's laboratory services according to the terms and conditions of the certificate.

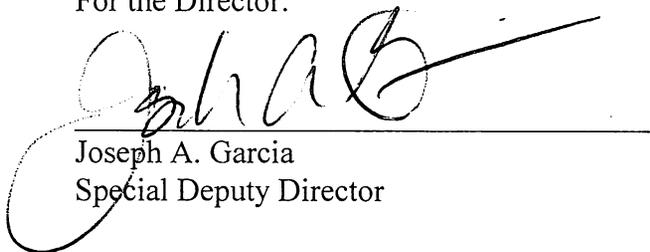
**V. ORDER**

The Director upholds BCBSM's May 19, 2015, final adverse determination.

This is a final decision of an administrative agency. Any person aggrieved by this order may seek judicial review no later than 60 days from the date of this order in the circuit court for the Michigan county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1). A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin  
Director

For the Director:



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Joseph A. Garcia  
Special Deputy Director

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<sup>3</sup> The tests might have been covered if they had been performed for diagnostic purposes rather than for preventive or screening purposes.