

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

**In the matter of:**

██████████  
**Petitioner**

**v**

**File No. 154773-001-SF**

**Rochester Community Schools, Plan Sponsor**  
**and**  
**Blue Cross Blue Shield of Michigan, Plan Administrator**  
**Respondents**

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**Issued and entered**  
**this 16<sup>th</sup> day of August 2016**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On July 25, 2016, ██████████ (Petitioner) filed a request for external review with the Department of Insurance and Financial Services, appealing a claim denial issued by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM is the administrator of the Petitioner's health benefit plan which is sponsored by Rochester Community Schools.

The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952) The Rochester Community Schools plan is such a self-funded plan. The plan benefits are described in BCBSM's *Community Blue Benefits Certificate ASC*.

On August 1, 2016, after a preliminary review of the information submitted, the Director accepted the Petitioner's request for external review. The Director notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on August 9, 2016.

This case presents an issue of contractual interpretation. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

## II. FACTUAL BACKGROUND

On December 2, 2015, the Petitioner went to Seton Cornerstone After Hours Medical Care, an urgent care facility. The Petitioner believed she had a urinary tract infection. A urine sample was taken. The sample was processed on December 7, 2015, by St. John Hospital and Medical Center where tests were performed for chlamydia and gonorrhea. BCBSM provided coverage for the urgent care visit but denied coverage for the urine tests.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, on June 3, 2016, BCBSM issued a final adverse determination affirming its decision. The Petitioner now seeks the Director's review of that adverse determination.

## III. ISSUE

Was BCBSM correct to deny coverage for the Petitioner's laboratory tests?

## IV. ANALYSIS

### BCBSM's Argument

In the final adverse determination issued to the Petitioner, BCBSM wrote:

The reported procedures Chlamydia and Gonorrhea screening (procedure code 87491 and 87591), are only covered when performed as preventive services as mandated by the Patient Protection and Affordable Care ACT (PPACA). They are not covered when performed as diagnostic services for a medical condition. In your case, the provider reported a medical diagnosis. Therefore, you remain liable for the non-covered charges.

On the date of service, you were covered under the *Community Blue Group Benefits Certificate ASC*. On page 72 of your certificate under **Preventive Care Services** it states that we pay for the "laboratory and pathology services for one routine Pap smear per member, per calendar, when prescribed by a physician." However, the services reported, procedure code 87491 and 87591 were reported as routine/diagnostic services with diagnosis code Z13.9 (Encounter for screening, unspecified), which is not

considered preventive. As a result, the claim denied appropriately and you remain liable for the non-covered services.

In your appeal letter, you indicated that you did not request these tests, and that the doctor ordered them without your consent, therefore, you should not be responsible for the non-covered charges. While I understand your concern regarding your liability for these services, because laboratory and pathology services were performed, you remain liable for the charges.

In an email submitted to DIFS on August 9, 2016, a BCBSM analyst offered this explanation for the coverage denial:

[Petitioner] is appealing BCBSM's denial of payment for laboratory services (procedure codes 87591 – infectious agent detection by nucleic acid (dna or rna); neisseria gonorrhoeae, amplified probe technique and 87491 - infectious agent detection by nucleic acid (dna or rna); chlamydia trachomatis, amplified probe technique) rendered on December 7, 2015. The service denied as it is not payable with a diagnostic diagnosis. [sic]

\* \* \*

At the time the service was rendered, [Petitioner] was enrolled in coverage through Rochester Community Schools, a self-funded group. The coverage was governed by the terms of the *Community Blue Group Benefits Certificate ASC*.

**Section 3: What BCBSM Pays For** (Page 73) of the *Certificate* under subsection **Preventive Care Services** explains the following:

**Routine Pap Smear**

Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.

\* \* \*

[Petitioner] received laboratory services on December 7, 2015. The services denied as not a benefit of the policy when reported with diagnosis code Z13.9 – encounter for screening, unspecified. Procedure codes 87591 and 87491 are only covered when performed as preventive services as mandated by the Patient Protection and Affordable Care Act (PPACA). They are not covered when performed as diagnostic services for a medical condition. [Petitioner's] provider reported a medical diagnosis (Z13.9). Therefore, the laboratory services denied appropriately.

Petitioner's Argument

In her request for an external review, the Petitioner wrote:

On 12/2/15, I went to Cornerstone After Hours clinic to seek medical attention for a UTI [urinary tract infection]. Treatment was received. I received a bill for treatment on 12/7/15 for "lab clinical" for \$190.00. After inquiry I was informed I was billed for STD tests. I did not request for this testing to be given, nor was I informed or give consent to this testing. At my 12/2/15 visit, I had only requested treatment for a UTI. I did not request for anything else.

The Petitioner does not believe she should have to pay for these tests.

### Director's Review

BCBSM is correct that the lab test in question were not preventive tests but rather were diagnostic tests. Preventive care is care received to prevent disease of illness. Diagnostic services are procedures used to determine the cause of an existing illness. The Petitioner went to an urgent care center because she believed she had a urinary tract infection. Any medical tests performed to help identify her disorder would be diagnostic in nature.

Because the tests were diagnostic, it was error for BCBSM to rely on the *Community Blue* certificate's preventive care provision. The *Community Blue* certificate has a provision, on page 31, that specifically addresses coverage for diagnostic tests:

### ***Diagnostic Services***

\* \* \*

#### Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology tests and services needed to diagnose a disease, illness, pregnancy or injury. Services must be provided:

- In a hospital (under the direction of a pathologist employed by the hospital) or
- By the patient's in-network physician or by another physician if your in-network physician refers you to one, or by an in-network laboratory at your in-network physician's direction.
  - Standard office laboratory tests approved by BCBSM performed in an in-network physician's office are payable. Other laboratory tests must be sent to an in-network laboratory.
  - You will be required to pay the out-of-network copayment if services are provided by an out-of-network laboratory or in an out-of-network hospital.

BCBSM's explanation of benefits form identifies the St. John Hospital and Medical Center as a participating provider.

Diagnostic laboratory tests are a covered benefit. Accordingly, the Director finds BCBSM's denial of coverage for the Petitioner's December 7, 2015 laboratory tests is inconsistent with the provisions of the Petitioner's benefit plan.

#### V. ORDER

The Director reverses BCBSM's final adverse determination. BCBSM shall immediately provide coverage for the Petitioner's December 7, 2015 laboratory tests subject to any applicable cost sharing requirements (deductibles, copayments, coinsurance). See MCL 550.1911(17). BCBSM shall, within seven days of providing coverage, furnish the Director proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. 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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Randall S. Gregg  
Special Deputy Director