Gilgal Practice

Dr. Oday • NPI 1234567890

Date Issued

October 10, 2025

Reference

APL-1760069978397

To

Blue Cross Blue Shield

Appeals & Grievances • Health Plan

Patient	Sarah Michelle Thompson
Member ID	BCT4782sa9364
Claim Number	BCT-2025-847392
Date of Service	June 15, 2025
CPT Codes	80053, 83036, 93000, 99215
Denial Code(s)	CO-50, Reason, Code
Amounts	Billed $847.00 • Denied $847.00

I am appealing your denial of claim BCT-2025-847392 for my patient Sarah Michelle Thompson (Member BCT4782sa9364). Your letter dated September 28, 2025 denied $847.00 for services I provided on June 15, 2025 citing After careful review of the submitted claim and medical records, this claim has been denied because medical necessity has not been established for the services provided. The documentation does not support the level of service billed (99215) or demonstrate that the diagnostic tests performed were .... The documentation supports coverage and payment under Blue Cross Blue Shield.

Your policy titled 'Blue Cross Blue Shield - medical necessity' states: 'This policy outlines coverage criteria for medical services and procedures. Services must meet medical necessity requirements as defined by evidence-based clinical guidelines.' Sarah's condition on the date of service featured critical indicators of medical necessity, including an A1C of 9.2%, blood pressure of 142/88, and chest pain. These clinical findings demonstrate that the services provided were essential for her acute care and management.

On June 15, 2025, Sarah presented with acute chest pain. Clinical findings included BP 142/88, HR 96 bpm, and reproducible chest discomfort on palpation of the chest wall. Given her presentation

with chest pain, diabetes (A1C 9.2%), and hypertension, the differential diagnosis included acute coronary syndrome, unstable angina, and musculoskeletal pain. For CPT 99215, this visit qualifies as high-complexity Medical Decision Making based on: (1) Problems addressed: acute chest pain, uncontrolled diabetes (A1C 9.2%), cardiovascular risk assessment; (2) Data reviewed: ordered and interpreted ECG, reviewed comprehensive metabolic panel results, analyzed A1C trend; (3) Risk: High risk of morbidity due to potential acute cardiac events requiring immediate diagnostic testing and treatment adjustment. Total visit time: 52 minutes.

The ECG was essential to rule out cardiac ischemia; delaying this test would have been inappropriate given the acute presentation. The comprehensive metabolic panel was required to assess electrolyte status and kidney function in the context of her chest pain and diabetes. The A1C was ordered because her elevated reading (9.2%, well above the goal of <7%) required immediate therapy intensification, and this result directly influenced treatment decisions made that day.

The American Diabetes Association Standards of Care in Diabetes—2024 recommend: 'A1C testing should be performed at least twice yearly in patients meeting treatment goals and quarterly in patients whose therapy has recently changed or who are not meeting glycemic goals.' also, the American College of Cardiology / American Heart Association Cardiovascular Disease Prevention Guidelines (2024) state: 'Baseline and interval ECGs are reasonable in patients with cardiovascular risk factors (hypertension, diabetes, hyperlipidemia) or symptoms suggestive of cardiac disease (chest pain, palpitations, dyspnea).' These guidelines clearly support the necessity for the tests performed during this visit.

Your denial states: "After careful review of the submitted claim and medical records, this claim has been denied because medical necessity has not been established for the services provided. The documentation does not support the level of service billed (99215) or demonstrate that the diagnostic tests performed were ...". This determination contradicts the documented clinical evidence. Total visit time: 52 minutes. This qualifies as high-complexity Medical Decision Making based on: (1) Problems addressed: chest pain, uncontrolled diabetes, hypertension assessment; (2) Data reviewed: A1C results, vital signs, metabolic panel, ECG interpretation; (3) Risk: High risk due to potential cardiac etiology, cardiovascular complications.

Medical necessity is unequivocally established by:
(1) Acute clinical indication on date of service: A1C 9.2% (not at goal (A1C 9.2%)), BP 142/88 (uncontrolled), chest pain
(2) Documented clinical decision-making directly dependent on these test results
(3) Immediate action taken based on findings that affected the treatment plan
(4) Substantial risk to patient health if services were delayed or not performed
(5) Compliance with national clinical guidelines for this presentation

Each service performed represents distinct diagnostic value: the E/M visit covers evaluation and decision-making; the diagnostic tests provided essential data that directly influenced treatment decisions that day. These are separately reportable services under NCCI guidelines, not bundled procedures.

The documentation demonstrates that these services were not routine screening or performed for convenience, but were medically essential to this patient's acute care needs that day. Denying coverage for medically necessary services contradicts both your policy language and the standard of care.

Your letter states: 'After careful review of the submitted claim and medical records, this claim has been denied because medical necessity has not been established for the services provided.' This determination contradicts the documented clinical evidence. Medical necessity is unequivocally established by: (1) Acute clinical indication on date of service: A1C 9.2% (not at goal (A1C 9.2%)), BP 142/88 (uncontrolled), chest pain; (2) Documented clinical decision-making directly dependent on these test results; (3) Immediate action taken based on findings that affected the treatment plan; (4) Substantial risk to patient health if services were delayed or not performed; (5) Compliance with national clinical guidelines for this presentation. Each service performed represents distinct diagnostic value: the E/M visit covers evaluation and decision-making; the diagnostic tests provided essential data that directly influenced treatment decisions that day. These are separately reportable services under NCCI guidelines, not bundled procedures. Denying coverage for medically necessary services contradicts both your policy language and the standard of care.

I request reversal of this denial and payment of $847.00. Timely filing regulations apply, and I am available for discussion with your medical director should you require further clarification. This is a timely first-level appeal.

Enclosures:
- Clinical notes from June 15, 2025
- Laboratory results
- ECG report
- Relevant clinical guidelines

Sincerely,

Dr. Oday

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Blue Cross Blue Shield - medical policy • (medical-policy) • Eff. 2025-10-10 • Retrieved 2025-10-10 • https://www.bcbs.com/providers/medical-policies

Blue Cross Blue Shield - medical necessity • (medical-necessity) • Eff. 2025-10-10 • Retrieved 2025-10-10 • https://www.bcbs.com/providers/medical-necessity