

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

In the matter of:

██████████

Petitioner

v

Blue Cross Blue Shield of Michigan

Respondent

File No. 146734-001

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Issued and entered  
this 30<sup>th</sup> day of March 2015  
by Joseph A. Garcia  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On March 10, 2015, ██████████ (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 March 17, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner has an individual health care plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Petitioner's health care benefits are defined in BCBSM's *Keep Fit and Member Edge Individual Market Certificate* and a rider establishing cost sharing requirements for the benefit plan.

The Director notified BCBSM of the external review request and asked for the information it used to make its adverse determination. BCBSM submitted the information on March 25, 2015.

The issue in this external review can be decided by a contractual analysis. 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 September 27, 2014, the Petitioner had lab work performed at ██████████ Hospital for his upcoming annual physical examination. ██████████ billed BCBSM \$351.00 for eight items, all of which were covered benefits. BCBSM paid its allowed amount on five items. On the

remaining three items (vitamin D test, PSA test, and blood draw fee) BCBSM assessed a deductible.

The Petitioner believes the PSA test and blood draw fee should be covered as preventive services without any cost sharing. The Petitioner appealed BCBSM's claim processing through BCBSM's internal grievance process. BCBSM held a managerial-level conference on January 23, 2015 and, at the conclusion of its internal grievance process, issued a final adverse determination dated January 29, 2015, affirming its claims decisions. The Petitioner now seeks a review of that determination from the Director. The amount in dispute is \$19.49.

### III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's PSA testing and related venipuncture?

### IV. ANALYSIS

#### Petitioner's Argument

In a letter dated January 5, 2015 accompanying the request for an external review, the Petitioner wrote:

On September 17, 2014, I went to the [REDACTED] facility to complete the bloodwork for my upcoming annual physical. I always complete the bloodwork in advance of the physical so that the doctor will be able to discuss the results with me during the visit. As this was part of my annual physical, I expected that the bill would have been paid in full by Blue Cross. However, it was not. The initial processing of the billing by Blue Cross from [REDACTED] resulted in all of the charges, \$351, being applied to my deductible. So, after discussing this with representatives from [REDACTED], they resubmitted the bill using the appropriate codes and the majority of the charges were paid by Blue Cross.

However, three specific charges were not paid and I am appealing two of those three. The first, for \$60, is for a PSA test, a standard test for a man of my age as part of a physical. The second, for \$13, is for the blood draw. It defies logic to think that Blue Cross would pay for a number of blood tests as part of an annual physical but not cover the act which makes that possible. The third test for Vitamin D was at my request and is not under appeal.

#### BCBSM's Argument

The final adverse determination issued to the Petitioner included this explanation of BCBSM's claim processing:

A review of your claim confirmed that your laboratory services were performed for a routine/preventive screening. However, the services in question identified by procedure codes 84153(Assay of PSA, total) and 36415 (Collection of venous blood by venipuncture) are not considered payable routine/preventive services under the terms of your health care plan. As such, the deductible applied to these services appropriately.

You are covered under the *Keep Fit and Member Edge Individual Market Certificate*. **Section 4: Coverage for Physician and other Professional Provider Services** (Page 4.20) of the Certificate explains the following:

We pay for facility and professional benefits for preventive care services and immunizations mandated by the Patient Protection and Affordable Care Act (PPACA) at the time they are provided, but only when obtained from a panel provider. Services obtained from a non panel provider are not a covered benefit.

We will pay 100 percent of our approved amount, not subject to any panel deductible, copayment or coinsurance requirements for the preventive care services and immunizations mandated by PPACA at the time they are provided.

A list of the preventive care services mandated by PPACA is available on our website, [www.bcbsm.com](http://www.bcbsm.com), and does not include the services in question.

Therefore, although those services were performed as preventive/routine services, they were not covered under the preventive benefit category; rather, those services were covered as medical necessary/diagnostic services. As indicated in **Section 8: The Language of Health Care** (Page 8.9) of your *Certificate*, a deductible is the amount that you must pay for covered services, under any certificate, before benefits are payable.

In addition, *Rider IOC \$10,000/\$20,000-I, \$13,500/\$27,000-0, \$13,500/\$27,000 OOPM Inpatient and Outpatient Cost- Sharing Requirements* amends the *Certificate* and requires you to satisfy the following annual deductible requirements for outpatient facility and professional services:

- \$13,500 for a one-person contract
- \$27,000 for a family contract (two or more members) .
  - One or more family members may satisfy the family deductible.
  - The full family deductible must be satisfied before covered services are payable for any member on a family contract.

Therefore, our approved amount of \$19.49 for the above mentioned services applied appropriately to your outpatient panel deductible requirement. Thus, you remain liable for the deductible requirement totaling \$19.49.

### Director's Review

Section 2713 of the Public Health Service Act<sup>1</sup> was added by the Patient Protection and Affordable Care Act (PPACA), a federal statute. It requires certain preventive care services to be provided without any cost sharing (e.g., deductibles). The part of section 2713 that is relevant to this review says:

**(a) In general**

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

The requirements in section 2713 are repeated, with slight elaboration, in a federal regulation that was issued to implement PPACA's preventive care mandates, codified at 45 CFR §147.130:

**(a) Services—**

(1) *In general.* Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

Thus, federal law requires health plans and insurers to cover without cost sharing those preventive care services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF)<sup>2</sup> A PSA test, which carries a “D” rating, is not a required preventive care service under the USPSTF recommendations which provide:

The U.S. Preventive Services Task Force (USPSTF) recommends against prostate-specific antigen (PSA)-based screening for prostate cancer.

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1. 42 USC § 300gg-13.

2. Found at <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (accessed March 30, 2015).

The USPSTF recommendations do not address venipuncture charges.

The amount charged for the PSA test was \$60.00. BCBSM's approved amount for the test was \$17.58 which was applied to the Petitioner's deductible. For the venipuncture (drawing blood for all the tests) [REDACTED] charged \$13.00. BCBSM's approved amount was \$1.91 which was also applied to the Petitioner's deductible. The total deductible charge for the two disputed claims is \$19.49. Because these claims are not part of the PPACA's rules and USPSTF recommendations requiring waiver of deductibles, BCBSM's claim processing was correct.

#### V. ORDER

The Director upholds BCBSM's January 29, 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 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.

Annette E. Flood  
Director

For the Director:



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Joseph A. Garcia  
Special Deputy Director