

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**

**Petitioner**

**File No. 110585-001**

**v**

**Time Insurance Company**  
**Respondent**

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**Issued and entered**  
**this 4<sup>th</sup> day of January 2011**  
**by Ken Ross**  
**Commissioner**

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On March 8, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted the Commissioner accepted the request on March 15, 2010.

The Commissioner notified Time Insurance Company (Time) of the external review and requested the information used in making its adverse determination. The information was submitted by Assurant Health, which provides administrative services for Time's insurance policies.

The issue in this matter can be decided by analyzing Time's certificate of medical insurance (the certificate), the contract that defines the Petitioner's health care coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

## II FACTUAL BACKGROUND

The Petitioner has individual health care coverage with Time through a PPO plan. Time uses the Cofinity network for its participating providers.

On January 13, 2010, the Petitioner received outpatient heart catheterization services from XXXXX, MD, a participating provider. Claims were submitted using procedure codes 93580, 93542, and 99219. Time covered procedure codes 93580 and 99219 and applied its allowed amounts for those services to the Petitioner's annual deductible. Time declined to cover procedure code 93542, saying it was included in code 93580 and should not be billed separately. The provider's charge for procedure 93542 was \$300.00.

The Petitioner appealed Time's handling of his claim. After exhausting Time's internal grievance process the Petitioner received a final adverse determination dated February 25, 2010.

## III ISSUE

Did Time correctly process the procedure code 93542?

## IV ANALYSIS

### Petitioner's Argument

The Petitioner says he is confused about his insurance coverage. He says he was told the catheterization would be covered and "had no idea anything would be in question." He states:

I had purchased this health insurance to cover me in time of need and I would say that having a stroke at such a young age and another spell would entitle me coverage on this matter. Seeing how I am in excellent health, and not having a medical problem in the past, and according to the doctors I am in very good shape for the future also. I feel now that I have been misled with this insurance policy, that I would be covered for sickness such as this. I feel that I have paid the policy premiums on time, every time, and continue to pay them on time.

The Petitioner believes Time did not correctly process the claims for his catheterization.

### Time Insurance Company's Argument

Assurant processed the Petitioner's claims as follows:

Procedure Code	Provider's Charge	Time's Allowed Amount	Discount	Ineligible Or Not Covered Charge	Applied to the Deductible	Petitioner's Responsibility
93580	\$ 1,400.00	\$ 1,067.89	\$ 332.11		\$ 1,067.89	\$ 1,067.89
93542	300.00			300.00		
99219	150.00	105.74	44.26		105.74	105.74
		\$1,173.63				\$ 1,173.63

The Petitioner's plan includes a \$5,700.00 calendar year deductible for certain services received from network providers like Dr. XXXXX. The certificate says (p. 4) that outpatient services are subject to the deductible and coinsurance.<sup>1</sup> Since the deductible had not been met at the time the services were performed, Time applied its allowed amount for procedures 93580 and 99219 to the Petitioner's deductible.

Time informed the Petitioner on the remittance advice form dated January 21, 2010, that Dr. XXXXX had agreed to accept Time's negotiated allowed amount and that he should not be billed for the discount to Dr. XXXXX's charge.

In its February 25, 2010, final adverse determination, Time also explained its reason for not covering procedure code 93542:

This request along with all submitted information was sent to our Health Management department for review. According to their review, procedure code 93542 is used to report an injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography. Procedure code 93580 is used to report a percutaneous transcatheter closure of a congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant. Per the documentation submitted, the provider performed a closure of a congenital atrial septal defect and then injected IV contrast into the right atrium for a bubble study to determine a successful closure. This injection is considered to be integral to the primary procedure and not separately reportable. In addition, CPT guidelines for code 93580 state, "Percutaneous transcatheter closure of atrial septal defect includes a right heart catheterization procedure. Code 93580 includes injection of contrast for atrial and ventricular angiograms."

Time believes that it processed the Petitioner's claims according to the terms and conditions of the certificate and is not responsible for any further benefits.

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<sup>1</sup> The coinsurance for services from network providers is 0%.

Commissioner's Review

The Petitioner's health plan includes a \$5,700.00 calendar year family deductible for network services. The family deductible is the dollar amount of covered charges from network providers that must be satisfied before Time pays any benefits.

The certificate is clear that the outpatient services the Petitioner received were subject to the deductible; nothing in the file shows that the deductible had already been satisfied at the time the services were rendered. Therefore, the Commissioner concludes that Time correctly handled the claims for the services on January 13, 2010.

The Petitioner says he thought his catheterization procedure would be "covered." Apparently he did not understand that under his certificate a medical service that is subject to the deductible may be "covered" and yet he may still be responsible for the out-of-pocket cost of the service until the deductible is satisfied for the year. Perhaps Time did not explain how the plan worked during the grievance process. The Commissioner concludes that Time correctly processed the deductible for Petitioner's claims related to his January 13, 2010, outpatient catheterization.

Assurant also concluded that procedure code 93542 should not be separately payable because it is included in procedure code 93580. Dr. XXXXX disputes that contention. The Commissioner observes that this is a dispute that does not involve the Petitioner and should be taken up by Time, the Cofinity network, and Dr. XXXXX. The Petitioner is responsible only for \$1,173.63, the amount applied to the deductible.

**V  
ORDER**

The Commissioner upholds Time Insurance Company's final adverse determination with respect to the calculation of Petitioner's deductible. The Commissioner reverses Time's final adverse determination with respect to the handling of procedure codes 93542 and 93580; whether these procedure codes should be billed separately, the Petitioner is not responsible for any additional payment.

Time Insurance Company shall, within seven days of providing coverage, provide the Commissioner proof it has implemented the Commissioner's Order. To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Regulation, 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.