

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 119863-001

Time Insurance Company
Respondent

Issued and entered
this 26th day of August 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 7, 2011, 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.* The Commissioner accepted the request on March 14, 2011.

The Petitioner's health care benefits are defined in a short term medical policy issued by Time Insurance Company (the certificate). (Time's claim processing is administered by Assurant Health.) Petitioner's coverage became effective January 1, 2010, and terminated June 30, 2010.

The issue here can be decided by applying the terms of the certificate. The Commissioner 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 June 27, 2010, Petitioner received an MRI at XXXXX in XXXXX. The purpose of the MRI was to assess shoulder pain caused by an earlier injury in which the Petitioner broke her arm. The Petitioner's initial treatment had been at the XXXXX. The Petitioner elected to have the MRI at XXXXX because XXXXX did not have an open MRI machine and the Petitioner has

severe claustrophobia. XXXXX is not a member of Time's provider network. Consequently, Petitioner's out-of-pocket cost was substantially higher than her cost for an MRI at XXXXX.

Petitioner disputes the amount Time paid toward her claim and appealed the denial through Time's internal grievance process seeking payment of the difference. Time did not alter its denial and issued a final denial of Petitioner's appeal on January 5, 2011.

III. ISSUE

Did Time Insurance Company correctly pay the Petitioner's June 27, 2010, MRI claim under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

Petitioner wrote the following in her October 25, 2010, letter to Time:

I'm appealing the "allowed amount" for this claim because:

The "provider comparisons" list that Cost Management Technology sent to me is not based on providers with open MRI machines. I didn't have the option of going to one of these providers. As far as I have been able to determine, XXXXX is the only provider on the list that offers an open [MRI] machine. The only other providers I was able to learn of in the overall XXXXX region are two outpatient facilities (with machines that don't have the same level of field strength as the XXXXX machine).

Thus, on the one hand, it seems that the comparison list would be different from the one that Cost Management Technology used. It seems that it would be a list of providers that provide the service. And yet on the other hand, XXXXX – the other primary facility in my "community" (the term used in my policy under the description of "reasonable and customary") - - provided a price estimate for this procedure with a non-open MRI machine that was essentially the same as the XXXXX price for the open machine. The XXXXX estimate, attached, is slightly higher. (I requested the estimate last week as I learned more about the basis for the amount allowed for the claim, not because I considered a non-open machine.)

Although I was told by an Assurant customer service representative that the only issue for the limited coverage was XXXXX's exorbitant pricing (and that Assurant goes all the way up to the 95th percentile for what it considers allowable), the XXXXX is not higher than what is in my community. These two hospitals provide the vast majority of services in my county. I requested the XXXXX estimate because XXXXX has no community reputation for premium

pricing; it was all puzzling.

Respondent's Argument

In its final adverse determination dated January 5, 2011, Time denied coverage for the MRI stating:

The statistical database used in determining a reasonable and customary amount for outpatient facility charges is provided through Cost Management Technology (CMT). CMT has one of the largest charge-based outpatient facility charge index databases in the country. CMT sources for data are received from all over the United States, including state agencies and insurance companies. This database is broken down by geographical area, is based on the procedure(s) performed and takes into account the amounts charged by other providers for similar services.

The services by XXXXX on June 27, 2010 were considered as listed below:

Procedure Code	Charge	Allowable
n/a	\$1,756.50	\$1,035.46

We reviewed this request and determined that we are unable to allow additional benefits. The reasonable and customary amount has been provided.

Commissioner's Review

The Petitioner's certificate of coverage provides that Time will pay for approved claims that are "reasonable and customary" which is defined on page 7 of the certificate:

REASONABLE AND CUSTOMARY AMOUNT: The lesser of:

1. The actual charge; or
2. What the provider would accept for the same service or supply in the absence of insurance; or
3. The reasonable amount, based on one or more factors such as:
 - a. The amount of resources expended to deliver the service or supply; or
 - b. The amount charged for the same or comparable service or supply in a community similar to where the service or supply is furnished; or
 - c. The costs incurred by providers in a community similar to where the service or supply is furnished and the amount by which the service or supply is commonly marked up by providers; or

- d. Charging protocols and billing practices generally accepted by the medical community or specialty groups, including charging protocols and billing practices related to Medicare; or
 - e. Inflation trends by geographic region; or
4. Another schedule or method of deriving charges, as identified in the Benefit Summary.

Based on the information provided in the final adverse determination, it appears that Time uses factors 3(b) and (c), quoted above, in determining the reasonable and customary payment for medical claims. The Commissioner recognizes that the Petitioner believes Time's calculation is incorrect based on the Petitioner's own research into the costs of MRI services in the XXXXX area. However, the Commissioner lacks the expertise and resources to determine a reasonable and customary amount for medical services. In any case, the amount that an insurer establishes as its payment for a particular medical service is beyond the Commissioner's regulatory authority.

V. ORDER

Therefore, the Commissioner will not overturn Time Insurance Company's final adverse determination of January 5, 2011.

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 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. 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.

R. Kevin Clinton
Commissioner