

**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. 151829-001

HealthPlus of Michigan,  
Respondent.

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Issued and entered  
this 10<sup>th</sup> day of February 2016  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) had magnetic resonance imaging (MRI) on October 5, 2015. Her health plan, HealthPlus of Michigan (HPM), covered the procedure but applied its allowed amount to the Petitioner's unmet deductible.

On January 21, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of HPM's decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner has individual health care coverage through HPM, a health maintenance organization. The Director immediately notified HPM of the external review request and asked for the information it used to make its final adverse determination. The Director received HPM's initial response on January 22, 2016. After a preliminary review of the material submitted, the Director accepted the request on January 28, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL.500.1911 (7). This matter does not require a medical opinion from an independent review organization.

## II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in HPM's *Signature HMO Individual Certificate of Coverage* (the certificate) and its *Benefit Rider CN* (the rider).

The Petitioner's physician recommended that she receive an MRI of the breasts in addition to a yearly mammogram. The MRI was performed on October 5, 2015, by an affiliated provider. HPM's allowed amount for the MRI was \$1,029.62 and it applied the entire amount to the Petitioner's unmet deductible. Consequently, the Petitioner was billed for \$1,029.62 by the provider.

The Petitioner appealed HPM's decision through its internal grievance process. At the conclusion of that process, HPM affirmed its decision in a final adverse determination dated December 29, 2015. The Petitioner now seeks a review of that final adverse determination from the Director.

## III. ISSUE

Did HPM correctly process the Petitioner's MRI claim?

## IV. ANALYSIS

### Petitioner's Argument

On the external review request form, the Petitioner stated:

My breast specialist . . . stated that because I have the BRCA1 gene I should have a mammogram yearly and also a breast MRI yearly. Health Plus is denying the claim because I did not get prior authorization. I have not ever had to get prior authorization for anything including a breast MRI that I had several years before, so it did not occur to me that I needed that.

### Respondent's Argument

In its final adverse determination, HPM told the Petitioner:

HPM of Michigan (HPM) staff has reviewed your grievance requesting payment of a bill that you have received in the amount of \$1,029.62, for a breast Magnetic Resonance Image (MRI) which was rendered to you on date of service October 5, 2015 by McLaren Regional Medical Center. . . . HPM's Director of Consumer Services . . . has determined to deny your request, as the claim processed correctly according to the terms of your contract.

The decision is supported by the language in your enclosed Benefit Rider CN,

Section II, covered Services, 2.10 Diagnostic Radiological Services and Therapeutic Services;

\* \* \*

This benefit states that the member copayment is none, but the annual deductible applies. HPM's records indicate that at the time the service was rendered, nothing had been applied toward your deductible of \$1,750.00 per member (not to exceed \$3,500 per family). McLaren Bay Regional Medical Center submitted the claim in the amount of \$2,312.20. The total allowed amount for the claim was \$1,029.62, and applied toward your annual deductible. Reimbursement rates (allowed amounts) are determined by a provider(s) negotiated contract and may vary by individual provider.

The decision is further supported by the language in your Benefit Rider, Section 1, Deductible and Out of Pocket Maximus, which states:

Annual Deductible shall mean the amount a member must pay for Covered Services in a benefit year before HPM will begin paying for those Covered Services in that benefit year. Coverage for preventative Health Services listed in Section 2.6 of the Benefit Rider and fixed dollar Copayments are not subject to payment of the Annual Deductible.

As an explanation, a breast cancer screening mammogram is listed as a preventive service for women, in accordance with section 3406d of the Insurance Code, while a Breast MRI is not. Therefore, the claim has processed correctly according to your Diagnostic Radiological Services and Therapeutic Services benefit.

### Director's Review

The Petitioner says that HPM did not pay for the MRI because she failed to get prior authorization. However, HPM did not deny coverage for lack of prior authorization. It covered the procedure according to the terms and conditions of the certificate and correctly applied its allowed amount to the Petitioner's deductible.

The certificate (p. 3) defines "deductible" as

the annual amount you must pay before we will pay for certain Covered Services under this Certificate. For example, if your Deductible is \$1000, we will not pay anything until you have paid \$1000 for Covered Services that are subject to the Deductible. If you have a Deductible, it is shown on your Schedule of Deductibles and Copayments.

The rider (p. 1) establishes the Petitioner's deductible as "\$1,750 per Member (not to exceed \$3,500 per family)." The Petitioner does not dispute HPM's assertion that nothing had been applied to the Petitioner's deductible at the time the MRI was performed.

The rider, in section 2.10, “Diagnostic Radiological Services and Therapeutic Services” (pp. 12-13), also says that MRIs are subject to the annual deductible. Therefore, the allowed amount for the MRI would be applied to any unmet portion of the deductible before HPM made any payment. The Director concludes that HPM correctly applied the entire \$1,029.62 of its allowed amount to the deductible.

The federal Patient Protection and Affordable Care Act does require that certain preventive care services be provided without cost sharing (i.e., deductibles, copayments, and coinsurance). However, a breast MRI is not one of those services.

The Director finds that HPM’s application of \$1,029.62 to the Petitioner’s deductible for her MRI is consistent with the terms of her coverage.

**V. ORDER**

The Director upholds MHP’s December 29, 2015, final adverse determination.

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 Michigan 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