

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. 153833-001

Priority Health,

Respondent.

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Issued and entered  
this 16<sup>th</sup> day of June 2016  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) wanted his health plan to cover services he received from out-of-network providers. His request was denied.

On May 24, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of the denial under the Patient's Right to Independent Review Act. MCL 550.1901 *et seq.*

The Petitioner receives group health care benefits through Priority Health, a health maintenance organization. The Director immediately notified Priority Health of the external review request and asked for the information it used to make its final adverse determination and it responded on May 31, 2016. After a preliminary review of the material submitted, the Director accepted the request on June 1, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues under 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 described in a certificate of coverage issued by Priority Health (the certificate).

In January 2016, after a sleep study, the Petitioner was diagnosed with obstructive sleep apnea (OSA). [REDACTED], MD, a sleep medicine specialist, recommended he get an oral appliance to treat his condition and gave the Petitioner the names of two providers who could fabricate the appliance: [REDACTED], DDS, and [REDACTED], DDS. Neither dentist is in Priority Health's provider network.

On January 19 and March 2, 2016, the Petitioner was seen by Dr. [REDACTED]. On March 2, 2016, the Petitioner had a consultation with Dr. [REDACTED]. Priority Health denied coverage for this care. It also furnished the Petitioner with the names of two network dentists it said could perform the needed services: [REDACTED], DDS, and [REDACTED], DDS.

When the Petitioner requested retro-authorization for the services from Drs. [REDACTED] and [REDACTED] (and also authorization for future services from Dr. [REDACTED]), Priority Health denied the request on the basis that appropriate treatment was available from network providers. The Petitioner appealed the denial through Priority Health's internal grievance process. At the conclusion of that process, Priority Health issued a final adverse determination dated May 6, 2016, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did Priority Health properly deny coverage for the January and March 2016 services from Drs. Robison and Ely?

### IV. ANALYSIS

#### Petitioner's Argument

Before he filed his request for an external review, the Petitioner submitted a complaint about Priority Health to the Department of Insurance and Financial Services in which he said:

Priority Health denied both my grievance and appeal to receive out of network coverage for an oral appliance recommended to treat my sleep apnea. There were only two in-network providers in the metro Detroit area and I had issues with both, which would make receiving treatment from either difficult. I requested that either of two out of network providers recommended by the sleep center - themselves an in-network provider - be allowed to be used and Priority Health allow these services to [be] treated as "in network" for claims and charges purposes. They do allow exceptions to their in network rules and I was asking for such an exception in my situation. . . . The office visits and treatment dates range from mid January 2016 up to end of March 2016.

During the internal grievance process the Petitioner explained why he did not want to use the in-network providers identified by Priority Health:

There were only two providers of oral appliances in the Priority Health network for the entire metro Detroit / Ann Arbor area.

The first provider was Dr. [REDACTED]. Their office did not return any calls or emails. The sleep center and all physician I met with strongly discouraged me from seeing anyone but a specialist with experience in treating sleep apnea. They stated that many dentists and providers could fabricate an oral appliance, but that problems could occur if they are not sufficiently trained and experienced in working with sleep apnea patients. It could actually do more harm than good. Priority Health did reach out to them and they then called me, but after my research and follow up with sleep center, found that Dr. [REDACTED] does not specialize in oral appliances, but only does them as part of his dental practice.

The other provider in the network I saw was Dr. [REDACTED]. It took multiple calls and emails to get them to get in touch with me and set up an appointment. The visit was less than favorable as the doctor didn't even read the sleep study until I was in the exam room. After looking at it for literally a minute, he proceeded to do quick exam and tell me what type of appliance I needed. He did not bother to ask many questions or find out more information before making his determination. I saw him for all of 10 minutes. That, plus a quick set of impressions and an x-ray resulted in them asking me to pay 4500. When I got the explanation of benefits later, I found that they had actually submitted a bill to [Priority Health] for \$700, \$200 more than they had told me at the office. All for less than 20 - 30 minutes of actual time being treated or met with. Fortunately, insurance covered most of this. Though I would point out that the amount Priority Health paid the provider, \$441, was higher than the other two out of network specialists were charging me for the initial consult and exam. Dr. [REDACTED] office could not provide me with any estimated treatment length or cost of the appliance. They were not very helpful and seemed more interested in getting me out of there and collecting a fee than really addressing my needs. I've called twice since my initial appointment and never heard back from them. . . .

These were the only two options that Priority Health has for me to do the oral appliance. Both were over 30 miles from my work and home, adding to the inconvenience. Given that Dr. [REDACTED] was very expensive and did not take much time with me, was not helpful, it did not make sense to go back to there for treatment. I have doubts that they will do an effective job and based on what they charged for my initial visit, they would not be very cost effective in the long run. With Dr. [REDACTED] only being a general dentist who does not specialize in sleep apnea treatment, I do not believe that to be an effective option.

### Respondent's Argument

In its final adverse determination, Priority Health explained the reasons for its denial:

Uphold denial - requested coverage will not be provided. Service is available in plan. Service with Non-Participating Providers is not a covered benefit when medically appropriate treatment is available within the Priority Health Network of Providers in accordance with the Certificate of Coverage. The accepted standard of care is available in plan.

The Appeal Committee understands [the Petitioner's] wishes to continue services with Dr. [REDACTED] due to her familiarity and established relationships with Dr. [REDACTED], however [his] HMO contract requires he seek care from Participating Providers whenever possible. The Appeal Committee did not feel an exception to this requirement was appropriate in this situation.

### Director's Review

The certificate's "Schedule of Copayments and Deductibles" indicates that prosthetic and orthotic devices, such as an oral appliance, are covered.

But the certificate (p. 8) also contains this provision regarding services from non-participating providers:

You do not need a referral from your PCP or Priority Health to seek Covered Services from a PHCS / MultiPlan Network Provider outside the Service Area (but within the United States) if you are a Covered Dependent child residing outside the Service Area. Prior Approval requirements described in item D. below apply.

You do not need Prior Approval or a referral from your PCP or Priority Health to seek Covered Services from a Retail Service Center located within the United States. Note: Coverage for Retail Service Center services is based on Reasonable and Customary Charges.

All other Covered Services you receive from Non-Participating Providers must be Prior Approved by us. If the standard of care (medically appropriate treatment) for your condition is not available from a Participating Provider, your PCP may ask Priority Health for approval to refer you to a Non-Participating Provider. If you do not receive approval from Priority Health prior to seeking Covered Services from a Non-Participating Provider, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, you will be responsible for payment. A referral from your PCP or another Participating Provider is not enough if you want the services to be Covered. If Priority Health approves the referral, we will notify your PCP or the Participating Provider who makes the request.

The certificate also this provision in "Section 7. Limitations" (p. 37):

You may only receive services from a Non-Participating Provider if your PCP or other Participating Physician has referred you and the services have been approved by us in advance. Otherwise, the services will not be Covered, and you will have to pay the entire cost. . . .

The Petitioner received services from two out-of-network providers. There is nothing in this record to show that Priority Health granted prior approval for those services. Therefore the Director concludes that Priority Health correctly denied coverage according to the terms and conditions of the certificate.

The Petitioner argues that Priority Health should allow an exception and cover the services from non-participating providers because he had issues with the two participating providers identified by Priority Health. While unfortunate, that is not an issue that can be resolved in a review under the Patient's Right to Independent Review Act (PRIRA). The Director cannot evaluate or compare the professional experience of providers or address quality of care issues.

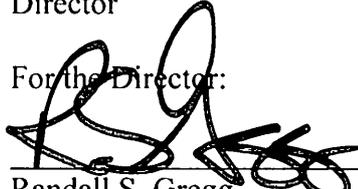
#### V. ORDER

The Director upholds Priority Health's May 6, 2016, 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 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