

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

In the matter of:

██████████

File No. 154068-001

Petitioner,

v

Priority Health,

Respondent.

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Issued and entered  
this 30<sup>th</sup> day of June 2016  
by Joseph A. Garcia  
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) has individual health care coverage as a member of Priority Health (Priority), a health maintenance organization. The Petitioner says she has not been able to access the massage therapy benefits available under her health plan and asked Priority to provide additional chiropractic visits instead. Priority denied her request.

On June 9, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of Priority's denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the request on June 16, 2016.

The Director immediately notified Priority of the external review request and asked for the information it used to make its final adverse determination. Priority responded on June 17, 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 defined in the *MyPriority HMO Agreement* (the agreement or contract). Her benefits include acupuncture services and massage therapy; those holistic services are administered by American Specialty Health Group, Inc. (ASHG),

under a contract with Priority.

The Petitioner says that so far this year she has been unable to use her massage therapy benefit, a problem she attributes to both Priority and ASHG. As an alternative, she requested 15 additional chiropractic visits (she has already reached the 30 chiropractic visit maximum for the contract year).

Priority denied the request and the Petitioner appealed through Priority's internal grievance process. At the conclusion of that process, Priority maintained its denial and issued its final adverse determination dated May 19, 2016. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did Priority correctly deny the Petitioner's request for additional chiropractic visits?

### IV. ANALYSIS

#### Petitioners' Argument

In her external review request, the Petitioner wrote:

The problem is that I have not been able to use my medical massage benefits through Priority Health and their affiliate ASH. I specifically purchased this plan for the medical massage! Due to errors with eligibility on Priority Health end and ASH providers not understanding the contract they have with Priority! I had tried prior to effective date (December 2015) to understand benefits but had to wait until January 2016 to talk to anyone about specifics. Priority Health acknowledges it did not provide ASH with proper info Jan. 1 through Feb. 19<sup>th</sup>.

I had filed an appeal / grievance with Priority Health and ASH about these issues. ASH providers in my area were trying to charge me 2x the \$30.00 copay for service! I believe this is fraud. I have not been able to receive services / benefits. I have been paying for five months. I have asked for extra chiropractic benefits (15) one half of what I get (30 each year) due to the fact I had to use more chiropractic care because I could not use medical massage.

I was told that this is just an inconvenience and I still have 20 visits for massage I can use for the remainder of the year. They denied the extra chiro visits because they are two different benefits and cannot be substituted. So, I would like partial reimbursement of premiums paid to date from Priority Health since this is who I make my payments to.

#### Priority's Argument

In its final adverse determination Priority said:

**Issue:**

[The Petitioner] is requesting coverage of 15 additional Chiropractic visits beyond her maximum limitation of 30 per year.

[She] states that she has already maxed out her 30 Chiropractic benefits because she has not been able to access her Massage Therapy benefits; due to Priority Health eligibility errors and providers that do not understand how the Priority Health Holistic Benefit works. [The Petitioner] reports she has paid her premium for the last five months and she would like some type of compensation for the Massage Therapy benefits she was not able to receive.

**Decision:**

Uphold benefit application - requested coverage will not be provided. Specifically, Priority Health processed the claims for Chiropractic services to apply the Rehabilitation Medicine Services benefit and maximum, in accordance with the MyPriority HSA HMO Agreement and Schedule of Copayments and Deductibles.

The Appeal Committee understands [the Petitioner] has not had a good experience with both Priority Health and ASH, and the Committee is deeply sorry for the inconvenience that [she] has gone through. However, [the Petitioner] currently does have access to the full 20 Massage Therapy visits through the end of her contract year under ASH, therefore the committee did not feel it was appropriate to grant additional Chiropractic visits under the medical benefit. Benefit limits and maximums apply even when continued care is Medically / Clinically Necessary beyond the benefit maximum. These two benefits are separate products, and one cannot be substituted for another.

**Director's Review**

Massage therapy is a covered service under the Petitioner's contract with Priority. It is not clear in this record exactly why the Petitioner had problems accessing the massage therapy benefit. Nevertheless, Priority does not deny her assertions nor has it submitted as part of this external review any information about how it proposes to correct the problems identified by the Petitioner.

As a health maintenance organization, Priority must "maintain contracts with those numbers and those types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay." MCL 500.3530(1). This includes providers whose services are managed by contractors such as ASHG. If Priority cannot furnish massage therapy services to the Petitioner through ASHG, then it must find alternative providers, even if they are out of network. Section 3530(2) of the Insurance Code says:

If a health maintenance organization has an insufficient number or type of participating providers to provide a covered benefit, the health maintenance organization shall ensure that the enrollee obtains the covered benefit at no

greater cost to the enrollee than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the [director]. MCL 500.3530(2).

The Director finds that the Petitioner has already experienced an "unreasonable delay" in procuring massage therapy services. Therefore, Priority must find a massage therapist outside its network if ASHG cannot supply one who will perform according to the terms and conditions of the Petitioner's contract. Priority is required to manage its subcontractors to insure that covered benefits are provided expeditiously.

#### V. ORDER

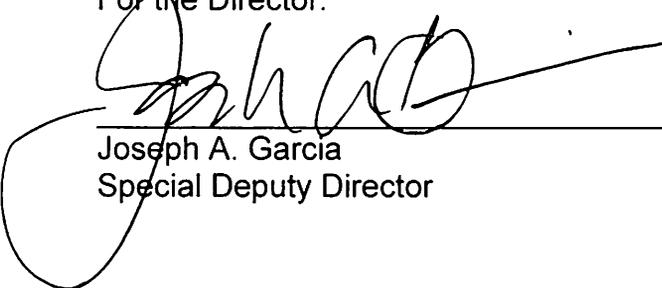
The Director modifies Priority's May 19, 2016, final adverse determination. The Director upholds Priority's decision to deny coverage for additional chiropractic visits. However, if massage therapy benefits cannot now be accessed through ASHG, Priority shall immediately make arrangements for massage therapy services to be provided to the Petitioner outside its network at no greater cost to the Petitioner than if the benefit were obtained from a network provider.

To enforce this Order, the Petitioner may report any complaint regarding compliance to the Department of Insurance and Financial Services, Health Care Appeals Section, at this toll-free number: (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 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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Joseph A. Garcia  
Special Deputy Director