

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. 153108-001

Priority Health HMO,
Respondent.

Issued and entered
this 26th day of April 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 6, 2016, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives group health care benefits from 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. Priority Health responded on April 12, 2016. After a preliminary review of the material submitted, the Director accepted the Petitioner's request on April 13, 2016.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. 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 the Priority Health's *HMO Certificate of Coverage* (the certificate).

From September 18, 2015, through February 3, 2016, the Petitioner had ten outpatient behavioral health visits with [REDACTED], LMSW, ACSW [REDACTED] is not in Priority Health's provider network. The charge for the ten visits was \$1,250.00.

Priority Health denied coverage for the mental health services rendered by Fry on the basis that participating providers were available to afford appropriate treatment.¹ The Petitioner appealed Priority Health's denial through its internal grievance process. At the conclusion of that process, Priority Health issued a final adverse determination dated March 10, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did Priority Health correctly deny coverage for the Petitioner's behavioral health services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner began counseling with [REDACTED] when she had coverage with another health plan. She wants to continue to see [REDACTED] even though the therapist is not in Priority Health's network because she has experienced trauma in the past and is making progress with [REDACTED].

Respondent's Argument

In its final adverse determination, Priority Health explained its decision:

Issue:

[The Petitioner] is requesting coverage of outpatient behavioral health services provided from September 18, 2015 through February 3, 2016, as well as future services with [REDACTED], LMSW, ACSW, a Non-Participating Provider.

[The Petitioner] states: I began personal counseling when we were under a different insurance plan. Because of the sensitive nature of the service disclosure information, progress, and continuity of care, I did not switch providers.

Consider coverage due to continuity of care for vendor [REDACTED].

Decision:

Uphold denial – requested coverage will not be provided. Service is available in plan. Service with Non-Participating Providers is not a covered benefit when

¹ Priority Health also denied the Petitioner's request for coverage of future visits with [REDACTED]

medically appropriate treatment is available within the Priority Health Network of Providers. In addition, prior approval was not obtained for services with a Non-Participating Provider, therefore the services are not a covered benefit in accordance with the Certificate of Coverage.

The Appeal Committee understands [the Petitioner's] wishes to continue services with [REDACTED] due to her familiarity and established relationship with this provider, however [her] HMO contract requires she 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 (p. 8) explains what must be done to receive services from a nonparticipating provider:

Non-Participating Providers

All 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.

* * *

D. Prior Approval Requirements.

Some services and supplies require Prior Approval by Priority Health in order to be Covered under this plan. The complete and detailed list of these services is available by calling our Customer Service Department or on our website at *priorityhealth.com*. This list may change throughout the Contract Year as new technology and standards of care emerge. Below are the general categories of services and supplies that require Prior Approval by Priority Health:

* * *

(3) Referrals to Non-Participating Providers.

There is no dispute that Fry is a nonparticipating provider or that the Petitioner had not received prior authorization from Priority Health to receive services from Fry. On that basis the

Director concludes that Priority Health's denial of coverage was correct.

Priority Health is a health maintenance organization (HMO). A fundamental premise of HMOs is the centralization of health care delivery within a network of providers who sign contracts and agree to accept negotiated rates. The negotiated rates are a primary method of containing costs that ultimately benefit all members. If an HMO member uses an out-of-network provider without authorization or when services are available from in-network providers, coverage for the out-of-network services may be excluded entirely by the HMO. There is nothing in the certificate or in law that would require Priority Health to make an exception for the Petitioner.

The Director finds Priority Health's denial of coverage for behavioral health services the Petitioner received from September 18, 2015, through February 3, 2016, to be consistent with the terms and conditions of the certificate.

V. ORDER

The Director upholds Priority Health's March 10, 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:



Randall S. Gregg
Special Deputy Director