

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

File No. 117612-001

v

Priority Health Insurance Company  
Respondent

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**Issued and entered**  
**this 25th day of March 2011**  
**by Ken Ross**  
**Commissioner**

**ORDER**

**I**  
**BACKGROUND**

On October 18, 2010, 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.* On October 25, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review. On October 28, 2010, Priority Health furnished the information used in making its final adverse determination.

The issue in this external review can be decided by an analysis of the policy that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

## II FACTUAL BACKGROUND

Petitioner had a history of right hip pain for which hip replacement was recommended. Prior to having surgery, she underwent physical therapy to treat her condition and received 24 visits for physical therapy in 2009.

On January 5, 2010, Petitioner had hip replacement surgery on her right hip. As part of her post-surgical rehabilitation she received 15 sessions of physical therapy. She requested additional therapy. Priority Health provided coverage for six additional sessions, but denied coverage for the 10 sessions provided in February 2010 asserting that Petitioner had exceeded the maximum number of visits available in a contract year. (Petitioner's contract years runs from March 1 to February 28.)

Petitioner appealed the denial through Priority Health's internal grievance process and received the final adverse determination dated September 30, 2010.

## III ISSUE

Did Priority Health properly deny the Petitioner coverage for additional physical therapy?

## IV ANALYSIS

### Petitioner's Argument

In her request for external review, Petitioner wrote:

I am being charged for 9 sessions of physical therapy that I thought were covered by Priority Health.

Per Priority Health, coverage of these sessions fell out of the "contract year."

At no time did I have any understanding that there was a difference between "calendar year" and "contract year" as evidenced by my calling in before and after surgery to verify coverage.

On the recordings I requested and received from Priority Health, I am clearly heard asking, "30 sessions per year?" and the Priority Health rep responds "Yes."

I am asking respectfully that my appeal be approved, for these sessions to be covered by Priority Health as I honestly feel I did my due diligence repeatedly and my understanding was in good faith.

Petitioner argues that Priority Health should make an exception to the certificate and extend her coverage for the nine additional physical therapy visits.

Respondent's Argument

Priority Health says that its denial of physical therapy visits was appropriate because the policy limits physical therapy coverage to 30 visits per contract year and the Petitioner was provided with coverage for those visits.

Commissioner's Review

Priority Health denied additional visits beyond the 30 allowed per contract year. The policy's Schedule of Benefits states the physical therapy benefit as follows:

Benefits	Network Benefits	Non-Network Benefits
<b>Physical and Occupational Therapy</b> (including spinal manipulation)	\$15.00 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year	<ul style="list-style-type: none"><li>• 50% Coverage of Reasonable and Customary Charges up to the combined benefit maximum of 30 visits per Contract Year</li><li>• Deductible applies</li></ul>

The term "contract year" is defined in the policy (page 52) as:

The period of time that starts on the day the Agreement is effective (the "renewal date") and ends 365 days later (unless the Agreement states otherwise). The Contract Year often begins on the date eligibility is effective after an Open Enrollment Period.

The Petitioner argues that additional visits are medically necessary and therefore Priority Health should provide coverage because she did not receive the maximum 30 allowed per year. While the Commissioner is sympathetic to Petitioner's situation, the Commissioner finds that Priority Health's ruling was consistent with the terms of the policy. There is no provision in the policy that would require Priority Health to provide additional physical therapy sessions.

**V**  
**ORDER**

The Commissioner upholds Priority Health's September 30, 2010, final adverse determination. Priority Health is not required to cover the Petitioner's additional physical therapy visits.

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 sixty 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.

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Ken Ross  
Commissioner